THE PRACTITIONERS' MONTHLY.

DETROIT MEDICAL JOURNAL

VOL IV. MAY, 1904. NO. 2

EDITOR:
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INDEX TO ADVERTISERS.

39th Annual Meeting,

Michigan State Medical Society,

AT

Grand Rapids, Michigan,

Wednesday, Thursday and Friday,

May 25, 26 and 27, 1904

Supplement to The Detroit Medical Journal,
May 16th, 1904.

PROGRAM.

THE COUNCIL.

Chairman—LEARTUS CONNOR, Detroit.
Secretary—W. H. HAUGHEY, Battle Creek.

Tuesday, May 24th, 7 o'clock P. M. Standard, at the Morton House.
Wednesday, May 25th, 4 o'clock P. M. Standard, at the St. Cecilia Building.
Thursday, May 26th, 4 o'clock P. M. Standard, at the St. Cecilia Building.
Friday, May 27th, 1:30 o'clock P. M. Standard, at the St. Cecilia Building.

Organization and Election of Officers.

HOUSE OF DELEGATES.

President—WM. F. BREAKEY, Ann Arbor.
Secretary—A. P. BIDDLE, Detroit.

FIRST DAY, WEDNESDAY, MAY 25th

9 a. m. Standard

1. Call to order.
2. Roll Call.
3. Reading of Minutes of the last Annual Meeting
4. Report of the Council
   Leartus Connor, Detroit, Chairman.
5. Report of Committee on Legislation and Public Policy
   W. H. Sawyer, Hillsdale, Chairman.
6. Report of National Legislative Council, A. M. A.
   Emil Amberg, Detroit, Michigan Member.
7. Miscellaneous Business
   a) Appointment of Committee on Nominations, to nominate.

1st, 2d, 3d and 4th Vice-Pres.
2 Representatives in House of Delegates, A. M. A., for 2 years.
To fix Place of Meeting for 1905.
Adjournment to General Meeting.

SECOND DAY, THURSDAY, MAY 26th

9 a. m. Standard

1. Reading of Minutes of Previous Meeting
   A. P. Biddle, Detroit, Secretary.
2. Unfinished Business.
3. Report of Committee to petition the Legislature for an appropriation for the establishment of a properly equipped Sanitarium for the Treatment of the Early Stages of Tuberculosis
   B. D. Harison, Sault Ste. Marie.
4. Report of Committee on Vital Statistics
   H. B. Baker, Lansing, Chairman.
5. Miscellaneous Business.

Adjournment to General Meeting.

THIRD DAY, MAY 27th

9:30 a. m. Standard

1. Reading of Minutes of Previous Meeting
   A. P. Biddle, Detroit, Secretary.
2. Unfinished Business.
3. Report of Committee on Nominations.
4. Miscellaneous Business.

Adjournment to General Meeting.

GENERAL MEETING.

ST. CECILIA BUILDING

President—WM. F. BREAKEY, Ann Arbor.
Secretary—A. P. BIDDLE, Detroit.

FIRST DAY, WEDNESDAY, MAY 25th

10:30 a. m. Standard.

1. Call to order.
2. Prayer — Rev. J. Herman Randall.
3. Address of Welcome
   Hon. Edwin F. Sweet, Mayor, Grand Rapids.
4. Report of Committee on Arrangements
   D. E. Welsh, Chairman.
5. Report from the House of Delegates
   A. P. Biddle, Detroit, Secretary.
6. Address of the President,
   Wm. F. Breakey, Ann Arbor.
   "Obligations of the State to conserve Life and Health."
7. Miscellaneous Business
   (a) Nominations for President

Adjournment.

8 p. m. Standard

National Auxiliary Congressional and Legislative Committee of the American Medical Association of the Counties of Michigan.

1. Introductory Remarks
   Emil Amberg, Detroit, Mich. Member National Legislative Council of the A. M. A.
2. Address
   To be Announced.
3. The Work of the Auxiliaries in their respective Counties
   J. B. Griswold, Grand Rapids.
4. The National and State Legislatures and the Auxiliaries
   H. A. Haze, Lansing.

Discussion general.

SECOND DAY, THURSDAY, MAY 26th

10:30 a. m. Standard

1. Unfinished Business.
2. Report of Committee to secure data regarding the prevalence of Venereal Diseases in Michigan
   A. E. Carrier, Detroit, Chairman.
3. Oration on Surgery
   H. E. Randall, Lapeer.
   "Abdominal Pain."
4. Oration on General Medicine
   David Inglis, Detroit.
   "A Message from the Clinician to the Laboratory Men."

5. Miscellaneous Business.
Adjournment.

THIRD DAY, FRIDAY, MAY 27th

10.30 a. m. Standard

1. Unfinished Business.
2. Report from the House of Delegates
A. P. Biddle, Detroit, Secretary.
3. Oration on Obstetrics and Gynecology
A. N. Collins, Detroit.
"Have we yet learned how potent for cure are the Natural Processes?"
4. Miscellaneous Business
At 12 o'clock Standard the result of the ballot for President will be announced.

Introduction of the President Elect
Adjournment.

SECTION ON GENERAL MEDICINE.

Chairman—R. H. Spencer, Grand Rapids.
Secretary—H. B. Britton, Ypsilanti.

FIRST DAY, WEDNESDAY, MAY 25th

1:30 p. m. Standard

1. The Prevention of Drug Habits
W. J. Wilson, Jr., Detroit.
2. Gastroptosis; Special Methods of Treatment
W. E. Newark, Charlotte.
3. Diagnosis of Diseases of Children
W. A. Ferguson, Sturgis.
4. What is the General Paralysis of the Insane?
Hiram A. Wright, Detroit.
5. The Test Breakfast in Diseases of the Stomach, with Report of Cases
Charles D. Aaron, Detroit.
6. Diagnostic Signs of Our Common Intestinal Parasites F. A. Maples, Battle Creek.
7. Cause and Rational Treatment of Pneumonia
H. J. Chadwick, Grand Rapids.

SECOND DAY, THURSDAY, MAY 26th

1:30 p. m. Standard

1. General Tic, with Report of Case
C. C. Wallin, Grand Rapids.
(Presentation of a Case of Rickets).
2. Intertracheal Injections
Willis S. Anderson, Detroit.
3. Hysteria, Certain Manifestations
Guy L. Connor, Detroit.
4. A Case of Persistent Vomiting
Collins H. Johnston, Grand Rapids.
5. Vascular Disease as a Factor in the Etiology of Epilepsy
Wm. J. Herdman, Ann Arbor.
6. A Pharmacological Study of Ethyl Salicylate
E. M. Houghton, Detroit.
7. Treatment of Chronic Otitis Media
J. G. Huizinga, Grand Rapids.

THIRD DAY, FRIDAY, MAY 27th

1:30 p. m. Standard

Election of Chairman and Orator of Section.

1. Pneumonia in Children
Loren Curtis, Paw Paw.
2. The Necessity for Periodical Examination in the Apparently Healthy
Alexander McKenzie Campbell, Grand Rapids.
3. Prophylaxis and Treatment of the Common Communicable Diseases of the Skin
H. R. Varney, Detroit.
4. Proctitis and Sigmoiditis
Wm. L. Dickinson, Saginaw.
5. The Value of the Tuberculin Test
I. H. Neff, Pontiac.
6. A Case of Colitis with Treatment
F. Holmes Brown, Newaygo.
7. Laryngeal Complication of Typhoid Fever
W. L. Wilson, St. Joseph.

SECTION ON SURGERY, OPHTHALMOLOGY AND OTOLOGY.

Chairman—D. EMMETT WELSH, Grand Rapids.
Secretary—JOHN W. MOORE, Atlantic Mine.

FIRST DAY, WEDNESDAY, MAY 25th

1:30 p. m. Standard

1. Removal of Second and Third Division of the Fifth Pair of Nerves after Emergence from the Skull, showing as good results as from removal of the Casserian Ganglion. This operation is much less difficult to perform, not dangerous and with slight deformity of the face
William Fuller, Grand Rapids.
2. Treatment of Intestinal Fistulas by the Elastic Ligature
Theodore A. McGraw, Detroit.
3. Myelitis Complicating Cancer of the Breast. Report of a case
F. B. Walker, Detroit.
4. The Treatment of Compound Fractures
A. I. Lawbaugh, Calumet.
5. Combined Use of Plaster of Paris and Elastic Traction in Deformities of the Feet
C. B. Nancrede, Ann Arbor.
6. Operations Upon the Prostate
E. B. Smith, Detroit.
7. Operation for the Removal of Triangular Depressed Fracture of Left Parietal Bone, Upper Middle Border (Recovery)
W. Earle Chapman, Cheboygan.

SECOND DAY, THURSDAY, MAY 26th

1:30 p. m. Standard

1. Differential Diagnosis of Conditions Simulating Appendicitis
L. J. Hirschman, Detroit.
2. Report of a Case of Cellulitis of Arm and Forearm I. D. Loree, Ann Arbor.
3. Diabetic Gangrene
Stuart E. Galbraith, Pontiac.
4. Cancer of the Rectum. Report of cases
J. A. MacMillan, Detroit.
5. Some Diseases of the Rectum, and the Treatment C. G. Darling, Ann Arbor.
6. Primary Carcinoma of the Ureter. Report of a case Wm. F. Metcalf, Detroit.
7. Chronic Suppurative Otitis Media, its Importance and Treatment
Don M. Campbell, Detroit.
8. History of the Mastoid and Radical Operation on the Middle Ear, with Demonstration of Anatomical Specimens
Emil Amberg, Detroit.

THIRD DAY, FRIDAY, MAY 27th

1:30 p. m. Standard

Election of Chairman and Orator of Section.

1. The Advantages of Early Operation in Hip Joint Disease
   E. C. Taylor, Jackson.
2. Congenital Dislocation of Hip. Reduction by Lorenz Method
   Angus McLean, Detroit.
3. The Closure of Wounds
   H. W. Yates, Detroit.
4. Interpretation of Radiographs
   Preston M. Hickey, Detroit.
5. Amblyopia from Methyl Alcohol Used Cosmetically
   Daniel Conboy, Bad Axe.
6. Adventurers in Surgery
   C. T. Newkirk, Bay City.
7. Tracheotomy
   J. A. Heasley, Grand Rapids.
8. Postoperative Exophthalmic Goitre. Report of a case
   S. Edward Sanderson, Detroit.

SESSION ON OBSTETRICS AND GYNECOLOGY.

Chairman—L. S. GRISWOLD, Big Rapids.
Secretary—FLORENCE HUSON, Detroit.

FIRST DAY, WEDNESDAY, MAY 25th

1:30 p. m. Standard

1. The Operative Treatment of Cystocele and Procidentia Uteri
   John N. Bell, Detroit.
2. A case of Malformation of the Internal Genitals with the Reproductive Glands in the Labia Majora
   Charles L. Patton, Ann Arbor.
3. A Report of a Case of Epithelioma of the Vulva
   A. C. Reed, Ann Arbor.
4. Dysmenorrhoea
   Jeanne E. Solis, Ann Arbor.
5. A Plea for Early Trachelorrhaphy
   T. S. Sands, Battle Creek.
6. A report of Five Cases of Sarcoma of the Uterus
   Ralph L. Morse, Ann Arbor.
7. Chorio-Epithelioma Malignum. Report of case.
   Wm. F. Metcalf, Detroit.

SECOND DAY, THURSDAY, MAY 26th

1:30 p. m. Standard

1. Pregnancy; Hygiene of Pregnancy; Mechanism and Management of Labor
   Frank H. Weaver, Charlotte.
2. Injuries of the Parturient Canal Due to Childbirth, their Causation, Diagnosis and Treatment
   James E. Davis, Detroit.
3. The Use of Rubber Gloves as a Prophylaxis in Obstetrics
   F. J. W. Maguire, Detroit.
4. Ectopic Pregnancy
   Mortimer Willson, Port Huron.
4. Continued.—Report of a Case of Extra-Uterine Pregnancy
   George C. Hafford, Albion.
5. Bright's Disease and Pregnancy
   W. H. Sawyer, Hillsdale.
5. Continued.—Cause and Treatment of Puerperal Eclampsia
   A. N. Collins, Detroit.
6. Eclampsia and Vaginal Cesarean Section
   J. H. Carstens, Detroit.
7. Clinical Cases
   J. G. Lynds, Ann Arbor.

THIRD DAY, FRIDAY, MAY 27th

1:30 p. m. Standard

Election of Chairman and Orator of Section.

1. Hysteria; Its Relation to Obstetrics and Gynecology
   Geo. F. Butler, Alma Sanitarium.
2. Physiologic Therapeutics in Gynecology
   J. H. Kellogg, Battle Creek.
3. Infection of the Biliary Tract
   H. W. Longyear, Detroit.
4. The Diagnosis and Treatment of Intraligamentous Ovarian Cysts
   Rolland L. Parmeter, Ann Arbor.
5. Renal Hematuria of Unexplained Origin. Report of a case with Cessation after Nephrotomy
   Benjamin R. Schenck, Detroit.
6. Appendicitis. Personal Conclusions based upon Two Hundred Operative Cases
   Wm. Bishop, Bay City.
7. The Relation of the Appendix to Pelvic Disease, based upon a Clinical and Microscopical Study of Two Hundred Cases
   Reuben Peterson, Ann Arbor.

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THE DETROIT MEDICAL JOURNAL.

VOL. IV. MAY, 1904. NO. 2.

PUERPERAL INFECTION.*

By EDWARD T. ABRAMS, A. M., M. D.,
Dollar Bay, Mich.

Half a century has rolled away since that memorable Friday evening in Boston when our own Oliver Wendell Holmes read his epoch-making paper on "The Contagiousness of Puerperal Fever." Listerism, with its modifications, has robbed operative surgery of its terrible mortality; yet today motherhood is surrounded by the awful death-rate of nearly 10 per cent. and of that mortality, more than 75 per cent. is due to *puerperal infection.* Surely this is a standing opprobrium to our boasted scientific advancement and acquisition at the opening of the twentieth century.

The pathology and etiology of puerperal infection is as thoroughly understood, and the methods of prophyalaxis as easy of application, as are those of any disease in our nomenclature.

Among the organisms causing puerperal infection may be mentioned (a) the streptococcus; (b) the staphylococcus; (c) the gonococcus; (d) the bacilus coli communis; (e) bacillus diphtheriæ; (f) the gas bacillus, or the bacillus of Welch; (g) the bacillus typhosus; (h) sapræmia.

There is a very wide significance as to which or what germ or germs are found in a given case. It is very rare, indeed, that the streptococcus is found in the milder cases of infection, while it is wellnigh invariably found in the severer ones. In the milder cases, such germs as the *gonococcus, staphylococcus* and various other bacteria will be found. The streptococcic form of infection, therefore, will demand the closest attention and the most guarded prognosis.

If we would live up to the scientific light of today we will not neglect the bacteriological examination of the lochia. If we find the gonococcus we can heave a sigh of relief.

If the colon bacillus be discovered to be the cause, or if it be any of the ordinary putrefactive organisms, we may be spared much worry and apprehension; and yet it would be only prudent not to indulge in too much faith, hope and assurance from the bacteriological findings, for in some cases we may be led astray, and in not a few, perhaps a very large percentage, we shall have to do with a mixed infection. Let us not forget that all cases of puerperal infection do not carry with them the same grave prognosis. Thus it is we sometimes hear of puerperal fever being cured by small doses of phenacetine, or by nothing more energetic than the vaginal douche.

From an anatomico-pathological standpoint, we may divide puerperal infection into three forms, viz: Endometritis, metritis and parametritis.

Endometritis may be subdivided into *putrid* and *septic.* Putrid endometritis is, in the vast majority of cases, caused by a remaining portion of placenta or membrane in the uterine cavity and becoming infected by microorganisms. Decomposition follows, inflammation of the endometrium is the result, and the virulence of the infecting organism will be the determining factor as to the severity of the case.

Septic endometritis, on the other hand, is caused by streptococcic infection, and the entire endometrium is covered with a dirty, yellowish looking exudate, and not infrequently we find areas of necrosis. The resulting pathology from this condition is very frequently an inflammation

*Read before the Houghton County Medical Society.
Detroit, Mich., May 16, 1904.

of the Fallopian tubes, followed by infection of the ovaries, the whole affair at last becoming one of pyosalphix, ovarian abscess, or both. Should the infection travel as far as the fibrinated extremity of the tubes and should they thereby not become occluded, we get infection of the pelvic peritoneum, and later general peritonitis.

Should the infection not be highly virulent, the inflammatory condition may confine itself to the pelvic peritoneum. It is in this class of cases that we get the pelvic cellular tissue secondarily infected, and there is developed the condition known as parametritis. Let us bear in mind the anatomical fact, that the pelvic cellular tissue is extra-peritoneal, and forms a bed in which the pelvic organs, together with blood vessels, muscles, and all tissues forming the pelvic floor, are enclosed. All the pelvic cellular tissue is situated *above* the pelvic fascia which covers the levator ani muscle, and all the cellular tissue of the vulva and the ischio-rectal fossa lies below this fascia. The amount and relation of this cellular tissue in the pregnant state differ very materially from the non-pregnant state, and in our study of puerperal infection this cannot be too carefully borne in mind. At the base of the broad ligaments it is very much increased. The ligaments are raised up to the brim by the growing uterus; in consequence of this, beneath the broad ligaments there is a triangular area on either side of the uterus, which is not covered by peritoneum, and as pregnancy advances, this area gradually becomes filled with new cellular tissue. Immediately contiguous to this new cellular tissue is a very large area situated behind Poupart's ligament. As the vesico-uterine pouch does not dip down into the pelvis as it did in the unimpregnated state, and the peritoneum does not dip into the lateral pelvis, we can readily see why the infection does not remain *pelvic* in the pregnant condition as it does in the non-pregnant. So also can we understand why so frequently in infection following delivery the cellular tissue *above the brim* becomes infected, and we have a large swelling behind Poupart's ligament. This altered arrangement of peritoneum and cellular tissue, which is brought about by pregnancy, very readily explains the position of some of the inflammatory swellings which occure during the puerperium, appearing as abdominal rather than pelvic, and which are not always so easy of diagnosis.

Pelvic cellulitis in the puerperal state must be a misnomer, for this parametritis is a result of a previous infection, and when we have the cellular tissue infected in this condition, it is always secondary to pelvic peritonitis.

The symptoms of puerperal infection will depend very largely upon the virulence of the infection, the type of tissue attacked and resistance offered by the individual to the absorption of the septic material. It is a very comforting belief to assume that the patient can and has infected herself; but the observations of men most competent to judge have been that this is not true except in certain instances. There may be an infecting coitus just previous to delivery, yet such a condition is by no means an auto-infection. More than 50 per cent. of prostitutes have latent gonorrhœa, and even in our best practice many honest women will be found in the same condition. These may, of course, infect themselves. There are cases, also, in which there is a focus of pus in either one or both of the adnexa, who going to full term, may infect themselves independently of the method or manner of delivery; and yet such conditions must be, from the very nature of the case, rare indeed, because the result in such conditions is almost invariably abortion or sterility.

Upon a correct diagnosis depends effective treatment. We believe it to be of prime importance to the instituting of treatment in any given case of puerperal infection that an effort be made to differentiate the types of infection we have to deal with. All cases of puerperal infection can no more be brought to a successful issue by the same mode of procedure than all cases of appendectomy can be handled from the same standpoint. Therefore, when brought face to face with a case of infection, a decision must be reached as to its type.

It will be noted that in the gonococcic form the fever will have a regular run, which in the streptococcic form will be found absent, and it will gradually decline to normal. The patient usually feels quite

well and has a smooth puerperium during the first week. In other words, the onset is late. The symptoms will gradually subside and the patient feels quite comfortable, but for a considerable tenderness which continues in the region of the uterus and tubes. A parametritis is very rarely seen, though the tubes in many instances can be easily palpated. Whertheim has demonstrated, however, that the pelvic cellular tissue may be infected by the gonococcus. In streptococcic infection we have early onset, high fever in contrast to moderate fever; a rapid and oftentimes irregular pulse. In the gonococcic form we have a remission of fever in from 36 to 48 hours, which does not occur in the former.

In sapræmia we have the history of retained placenta, foul-smelling lochia, etc. *There is no greater or more common error than to suppose that in puerperal infection we always have a foul-smelling lochia.* In point of fact, in infections due to the streptococcus or the staphylococcus, the lochia in the vast majority of cases *will be free from odor.* In sapræmia the uterus will be large, soft and more or less insensible to pressure, as against a small, firm and tender uterus in gonococcic infection. The essential point in the treatment of the gonococcic form is in the prophylaxis. We should begin at an early date in the case. If we have any doubt as to the previous morale of the tissues all discharges should be examined with the view of detecting latent gonorrhœa. The simple history of the case taken by itself will be of little or no value, for increased urination, with burning sensations, together with an increased vaginal discharge, is such a common accompaniment of pregnancy as to make these symptoms, when taken in the abstract, absolutely valueless. The essentials are the microscopic findings. When a positive result has thus been obtained, the douche should not be neglected. Absolute rest *after delivery* must be enjoined and will be of much more value than the more active and energetic procedures.

In sapræmic conditions the uterus must be freed of its abnormal contents. Nothing in point of safety and efficiency can take the place of the intelligent finger of the conscientious obstetrician. Of course, if this procedure be carried out in a half-hearted or apologetic manner, no good will follow. Therefore, anæsthesia should be produced and a complete operative procedure instituted. For us to defer action in this condition until our patient becomes constitutionally and thoroughly infected is to place ourselves in an unjustifiable position. The *sine qua non* of success in the vast majority of these cases is an early recognition of the pathological condition and the early application of radical measures, which is truly the most conservative treatment. At this period it is simply necessary that we empty the uterus of all decomposing material. The curette, especially the sharp curette, should not be used. If the os has contracted it must be redilated, and if too much force be necessary to accomplish this with the finger then the Goodell's dilator may be used, keeping always in mind that the less traumatism produced the better. After emptying the uterine cavity, use large quantities of saline solution, swabbing out the entire cavity with 50 per cent. alcohol. If the procedure has been done early enough and thoroughly enough the result will be that the chills will cease, pulse and temperature will go to normal or thereabouts and remain. For years we have not used sublimate as an intra-uterine douche, for the more we see of it in this connection, the more convinced are we of its uselessness.

But the puerperal sepsis due to streptococcic infection, unlike gonorrhœal or putrid, which tends to recovery, is rapidly fatal, or at best, seriously damages the pelvic organs to such a degree that our treatment must be governed not only by the *mortality* statistics, but by the *morbidity* as well. Curettage has given us a mortality that makes it prohibitive. This mode of treatment was very thoroughly gone over in a discussion of this subject before the Berlin Obstetrical Congress in 1891, and most of the authorities were opposed to this form of treatment. Fritsch called attention to the dangers of perforation and detachment of thrombi. He maintained that the *cervix* and not the uterus itself was the starting point

of the infection in the great majority of cases. Garrigues states that he has never seen a case of recovery in which curretage has been resorted to after sepsis was well established.

It is a well known fact that after all intra-uterine manipulations in puerperal sepsis, there is very frequently a temporary aggravation of the symptoms at least. This occurs not only after a curretage, but also after a digital exploration of the uterine cavity, or the giving of a simple intra-uterine douche.

Curetting is admissable only in cases in which we have evidence of retained products in the uterine cavity, and then it is to be accomplished by the intelligent finger of a conscientious obstetrician.

In 1898, a commission appointed by the American Gynæcological Society reported that Marmorek's serum had been used in 101 cases of streptococcic puerperal fever with a mortality of 33 per cent. Pryor, of New York, found 257 cases in which Marmorek's serum was used, but in which no bacteriological diagnosis was made, which gave a mortality of 16 per cent. Now, taking Williams', Krőnig's and Franz's percentage statistics, we shall find that about one-quarter of them were streptococcic, and as the remaining 75 per cent. would, in all human probability, have gotten well without the serum, there were some forty deaths in about sixty-three cases—a mortality of 63 per cent. This is certainly a mortality which must be prohibitive as to the treatment used. In the vast majority of cases the infection begins near the external genitals, viz.: tears in the perineum, vagina or cervix. If a thorough ocular examination more frequently took the place of the intra-uterine douche, we would be surprised to find how often the cavity of the uterus was *not* the invaded portal, but that the primary attack was nearer the external world, and traveled from there to the uterus, the Fallopian tubes, and lastly, the pelvic peritoneum. In not a few instances it reaches the pelvic peritoneum through the blood-vessels and lymphatics. All local treatment in the nature of intermittent washing and douching will be a waste of time. This is what Macharg did and had a death-rate of more than 50 per cent. The reason for this is not far to seek, for the pathogenic germs have passed in beyond the reach of such superficial treatment into the larger field of destructibility—*the general system*. Therefore, attack them in their first strong citadel. Make a broad incision into the posterior cul-de-sac. Do not make a vaginal puncture, which is an abomination unto all surgical procedures—but an incision free and generous. Through this all the fluids of the pelvis may be drained. In most cases we shall find much serum and lymph present, and in not a few some *pus*. Break down all false unions which may be found between the pelvic organs, and pack with iodoform gauze. I am well aware of the opposition from some quarters to iodoform gauze, yet we have not up to date, been able to locate a case in which iodoform poisoning has occurred from the use of gauze thus employed, or used *within* the puerperal uterus. Therefore, we do not think that iodoform gauze thus used can be considered dangerous.

Not infrequently the pathogenic germs will be found in the serum of the cul-de-sac when they are absent in the uterine cavity, and this for th reason that the infection has not been through the uterus itself, but through some other portion of the genital canal. The patient's nourishment should be kept above par, if possible, but elimination must be attained to with equal regularity. Hypodermoclysis will be found of real value in all cases, increasing the action of the kidneys and skin, and increasing the volume of the pulse.

Only those drugs should be used that are either stimulant or tonic in action. Alcohol should be given with a free hand. The limit to its administration should be the general intoxication of the patient, and oftentimes an enormous amount will be consumed before the condition is produced. They must be liberally fed and given large quantities of water. An ice-bag over the abdomen will give great relief in diminishing the pain, and will tend to retard the extention of the pelvic peritonitis.

Much has been claimed of late for Crede's ointment from some quarters. Personally, my experience with it has been very limited. "It is a soluble metalic silver made into a suitable ointment, which resembles very much the ordinary mercurial ointment. It is very rapidly

absorbed and disseminated into the blood current when applied to the skin." Roswell Park speaks very highly of it in general sepsis. However, it is one of the remedies which is still on trial, and one would hardly pin his faith to it alone in any given case of puerperal sepsis.

Hysterectomy for puerperal sepsis was most thoroughly discussed at the "Congress of Obstetrics and Gynecology." In Rome in September, 1902, Treub, of Amsterdam, expressed his opinion that hysterectomy for puerperal sepsis is very rarely indicated.

Tuffier, of Paris, gives to us the encouraging maxim: "To operate too early is criminal; to operate too late is *useless*." Either horn of the dilema would seem to be equally undesirable.

Freund, of Berlin, would limit it to cases (1) of total or partial retention of placenta which resisted all efforts at removal in the ordinary way. (2) Sases of abortion of criminal origin, when the treatment had not been aseptic, and pyæmic symptoms, together with metritis, had developed. But in the later period of puerperal sepsis, no matter whether it be of lymphangitic or of pyæmic origin, extirpation should not be done.

Leopold, of Dresden, who read one of the principal papers, took quite an encouraging view of the subject.

Zweifel, of Leipzig, did not agree with Leopold as to the encouraging results obtained from hysterectomy in peritonitis of puerperal origin.

A. Pinad, of Paris, called attention to the fact that the advocates might be divided into two hostile camps, viz.: the obstetricans who were against it, and the gynæcologists who were in favor of it.

Deaver, in a paper read before the American Surgical Association, makes use of the following language: "The results of hysterectomy in post-puerperal infection are more serious than extirpation for other infectious conditions. The constitutional disturbance must be the determining factor whether or not a hysterectomy shall be done; unfortunately, I regret to say that any operation is but too often contra-indicated for the above reason."

That hysterectomy is a justifiable procedure in the treatment of puerperal infection is admitted, but the indications are not always clear and well defined; therefore, it cannot as yet be considered of general application even in selected cases.

The real treatment of puerperal infection should be begun before it has occurred. The general application of the antepartum and postpartum douche in normal cases should be absolutely *condemned and abolished*, and even in cases of forceps or manual delivery, if done with due precaution, we believe they should not be used, as they are by far a greater element of danger than of safety to the patient. There can be no question, it would seem, that the general use of rubber gloves in obstetrical work would bring a very much lower mortality and morbidity in puerperal infection. We believe this to be especially true in the case of the general practitioner, whose work naturally calls him into all kinds of surgical and infectious diseases.

Tonight as we are discussing this most important subject can we not hear the final words of him who sleeps beneath the quiet shades of Auburn Hill, being echoed and re-echoed through the years of the departed century, "It is as a *lesson* rather than as a *reproach* that I call up the memory of these irreparable errors and wrongs. No tongue can tell the heart-breaking calamity they have caused; they have closed the eyes just opened upon a new world of love and happiness; they have bowed the strength of manhood into the dust; they have cast the helplessness of infancy into the stranger's arms, or bequeathed it, with less cruelty, the death of its dying parent. There is no tone deep enough for regret and no voice loud enough for warning. The woman about to become a mother, or with her new-born infant upon her bosom, should be the object of trembling care and sympathy wherever she bears her tender burden, or stretches her aching limbs. The very outcast of the streets has pity upon her sister in degradation, when the seal of promised maternity is impressed upon her. The remorseless vengeance of the law brought down upon its victim by a machinery as sure as destiny, is arrested in its fall at a word which reveals her

transient claim for mercy. The solemn prayer of the liturgy singles out her sorrows from the multiplied trials of life, to plead for her in her hour of peril. God forbid that any member of that profession to which she trusts her life, doubly precious at that eventful period, should hazard it negligently, unadvisedly or selfishly."

Dollar Bay, Mich.

TUMORS, CRANIAL AND INTRA-CRANIAL.*

By CHARLES W. HITCHCOCK, A. M., M. D.
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A writer in a recent number of the *Journal of the American Medical Association* quotes from a total of 1,642 autopsies 29 cases of brain tumor. If this be a fair average, nearly 1.8 per cent. of autopsies are brought about by these ruthless invaders of normal tissues, concerning the cause and nature of which we know all too little.

For our present purposes, it will suffice if we confine ourselves to a consideration of those growths which find origin from the cranium itself and the tissues within the skull. We too commonly think of these tumors as really only of the brain itself or at least as growths originating only from the nervous tissues within the skull. References to those tumors which spring from periosteal or osseous sites are comparatively few.

One of our text-books on Nervous Diseases thus introduces its chapter on "Tumors of the Brain:"

"The encephalon is frequently invaded by various new growths common to other parts of the body, and by a number of neoplasms that are practically found only within the skull. In addition, new formations arising from the meninges and cranial walls, while not strictly brain tumors, present symptoms that are identical with lesions of the cortex, and are localized in the same way. The term brain-tumor is here taken broadly to cover new formations within the skull."

This is a broader reference than most of our text-books afford and it is more scientific in its hint at the possibility of there being found other than cerebral and cerebellar growths.

Sutton, in his work on tumors, says: "The skull bones are by no means uncommon situations for sacomata, but they are attacked later in life than the long bones. Of the various bones two call for especial mention, viz., the maxilla and the mandible."

VonBergmann, Bruns, and Mickulicz's Practical Surgery contains the most careful discussion of the cranial growths which I have been able to find.

Sarcomata are spoken of as the most common, and of the sarcomata of the cranial bones these authors say that 60 per cent. of cases observed occur in the male and 40 per cent. in the female. They most commonly have origin from the temporal, then the frontal, parietal and occipital bones. Of 88 cases reported by Weiswange, 23 sprang from the periosteum and 40 from the diploic tissue. The spindle-and round-celled sarcomata are the most frequent and very few of the osteo-sarcomata occur. Not infrequently there is a history of injury preceding the growth. Their progress is very like that of other bone sarcomata; they grow rather quickly and metastasis often brings about an early death.

The giant-celled variety affords the best prognosis. The richer they are in cells, the more dangerous they seem to

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be. Some long-standing cases have proved to be of the spindle-celled variety.

Their inception is so insidious that they for some time often escape notice. Perchance a combing of the hair may call attention to the local changes which lead to the discovery of the growth.

The problem of deciding between a sarcoma of the bone and a sarcoma of the dura may present. These authors advise that if no external manifestations are present, the growth is clinically to be regarded as the equivalent of a brain tumor and so classed as an intra-cranial tumor, but from the moment of external manifestations we must seek to differentiate from various bone sarcomata, though this is by no means always possible. The majority of cases, it is said, develop as spindle-celled sarcomata. The brain symptoms are at first general headache, vomiting, slowing of the pulse, and then further on, pressure symptoms. Along with these symptoms but seldom without these symptoms, focal symptoms appear. An important point in determining the origin is the time of observation of the symptoms, whether prior to or after the physical detection of the growth itself. Exact diagnosis is here a most difficult problem and only under the most definite appearances can positive decision be made as to whether the growth is myelogenous, periosteal, or dural.

Rapid softening, breaking through the bone, especially at the center of the growth, frequently characterize those sarcomata arising from the bone itself (myelogenous) and these closely resemble perforating sarcoma of the dura.

The dural variety elevates the bony wall, but disturbs it through pressure from the inner to the outer aspect with progressive softening of the bone and there is usually a definite bony ring around the growth.

From the beginning of the diploic growth there is found a divergence of the two tables of the skull, these gradually separating from each other, while in the cases of dural origin there is found ragged and softened bone *en masse* without separation of the tables, and sharp spicules of the bony edges may be easily felt. It were easy, indeed, to differentiate between the sarcomata of periosteal growth and those of bony origin if only the former were composed of soft tissue and the latter had a distinctly bony covering or bony base.

When brain-pressure symptoms occur, especially if before or shortly after the appearance of the growth externally, the growth is apt to be of dural origin, and when undoubted brain-pressure symptoms or swelling appear, shortly after injury, we may decide upon a growth of the dura. They begin endo-cranially and cause pressure symptoms. If outward bulging occurs there is apt to be less pressure within and with prominent bulging outwards, the brain pulsation may then be transmitted externally. If on the other hand, the growth is crowded back upon the intra-cranial structures, headache, slowing of the pulse, and unconsciousness may occur.

The brain-pressure symptoms are not of themselves so important as the question whether they appear first or the growth itself is first in evidence. After external appearance upon the flat bones of the skull, growth is apt to be rapid and the difficulty of differentiating between those sarcomata of periosteal and those of myelogenous origin is great.

The base of the cranium is quite as frequently the site of the osteal and periosteal growths and here they behave not unlike other intra-cranial tumors, sometimes growing down into the nose and into the orbit, when they may of course take on symptoms due to the encroachment upon the eye or nose.

Metastatic growth may, of course, occur in the thyroid, kidney, or elsewhere. Only a positive knowledge of a primary growth on the ribs, spine, or long bones

will admit of a suspicion that the cranial growth may be secondary.

The foregoing abstract of Von Bergmann's reference to these tumors shows how carefully and thoughtfully tnese workers have taken up the problem of their growth. Nowhere else have I found any such extended or careful references.

As to the relative frequency of the intra-cranial occurrence of the different varieties of tumor, authorities differ somewhat.

One authority quotes tubercle as furnishing the largest proportion of brain tumors, another cites the growth peculiar to the nerve structures, viz., the glioma, as the most common, while still another writer believes the sarcomata more common than either. There would be at least no dispute that these three forms with the mixed forms of the glioma, e. g. the glio-sarcomata, are the most common forms found in these regions. Next come the syphilomata (gummata) and the carcinomata. "Cysts form tumors in the brain with comparative frequency."

Mention may be made, too, of cerebroma, fibroma, angioma, neuroma, psammoma, papilloma, actinomycosis, lipoma, teratomo, osteoma and cholesteatoma, but these of course are comparative rarities.

The immediate danger from brain tumor, of course is the destruction of adjacent brain tissue which it is almost sure to entail, either directly or indirectly, from interference with its nutrition by pressure. Peril is the least in the slow growing tubercles and the greatest in the rapidly growing glioma, so prone to infiltrate circumjacent tissue.

When we consider that "a slow growing mass starting from the meninges may deform an entire hemisphere without giving rise to symptoms, while another of insignificant volume may produce the most marked motor, sensory, and mental disturbances, or lead to sudden death," (Church),—it is obvious that the symptomatology must present variations between very wide limits.

In general, the common symptoms, as is well known, are headache, convulsions, mental impairment, optic neuritis or atrophy, vomiting and vertigo. Headache, vertigo and vomiting are especially common symptoms. When any or all of these symptoms shall have warranted a diagnosis of an intra-cranial growth, the conclusion is not far to seek that the prognosis is bad, save for the possible triumph of sugery, as practically no intra-cranial tumors aside from the syphilitic growths are susceptible of great benefit from treatment, although it is said that the administration of the iodides has served to check sarcomata by relieving existing œdema and has brought about temporary, and likely misleading, relief.

Even when the surgeon and the neurologist shall have together applied the refinements of localization, the path of the surgeon is by no means clear to an easy triumph. Many difficulties beset him in the possible nature of the growth, its intimate attachments, vascular connections, etc. To skiagraphy we may look for possible future aid.

It was my desire to call your attention to these growths even in this very cursory and imperfect way that I might emphasize the possibility of other origins than from the intra-cranial nervous structures and that I might then report the following case:

It was by the courtesy of Dr. G. E. Potter, that I saw S. B., in consultation with him, June 6, 1903. He was first called to attend her April 27, 1903, because of a cold, and he has enabled me to supplement my own notes of the case with his.

The patient was 62, married, and the mother of four healthy children. The only item of possible interest presented

by the family history is that a sister was operated on for, (died of) a tumor of the breast which was diagnosed as cancer.

The patient was unable to divest herself of the idea that what was apparently an attack of ptomaine poisoning about 20 years before, was the starting point of all her succeeding troubles. She apparently regards as insignificant the fact that about ten years ago Dr. McGraw removed a hard tumor from the right side of the neck (between the tongue and jaw, her husband says). Inflammatory rheumatism is said to have followed her ptomaine poisoning, involving the left hip, knee and ankle joints and terminating in ankylosis of each joint and a phlebitis of the left femoral from which she has suffered much pain and difficulty in walking.

For the past five years, she has been gradually failing, having for the past four years very severe headaches, most acute in the occiput. These were not worse at night, but would come on at any time and were easily aggravated by noises or disturbance of any kind.

Marked parietal bulging was observed, with widening of the forehead; this, with very marked exophthalmos, giving the patient an almost grotesque appearance. The exophthalmos had been very rapidly increasing recently, although present for a year or more. Acquaintances assured me that they could attest the development of the parietal bulging.

Patient was confined to her bed when I saw her, although she had been up and about her house until about May 1, 1903, and thereafter remained in bed on account of the severe headache and because of her fear of stumbling.

The patient talked clearly and with apparent intelligence of her history. There was no evident mental impairment.

Her pulse was observed to be 100, small and regular, respiration normal. Right pupil was much dilated and the left one slightly so. The left pupil showed a reflex to light, the right showed no response. Patient thought vision better in right eye, but very little in either. Retinas not examined. Heart sounds were normal, tongue red, bowels constipated. There was considerable antero-posterior curvature of the spine in the upper dorsal and the lower cervical region.

The arm reflexes were quick, the patellar reflexes could not be elicited. There were no sensory changes and no motor impairment save some alleged weakness of the left side and the stumbling. How much the impaired vision had to do with this it was difficult to say. A tentative diagnosis of probable tumor of the base of the brain was hazarded and a bad prognosis given. This latter was well confirmed by the progressive failure which terminated in death on July 19, 1903.

Autopsy was held about 12 hours after death. Body rather emaciated. Only the cranium was examined. On sawing through the frontal and parietal regions, the bone seemed tough and enormously thickened, but when we attempted to saw over the vault from ear to ear, the bony tissue seemed almost like paper, scarcely any of the tables being left and the diploic tissue being replaced with a soft pultaceous mass. The greatly thinned tables were widely separated; it was from this region that the specimen was taken for examination. On removal of the skull cap, the bone at its thinnest portion (temporal region) measured fully 7-8 inch in thickness and over the vault where it had seemed so thin and in the frontal region it measured 1 1-8 inches in thickness.

In the frontal region the hard tissue of the tables seemed much thickened, although the tables were here also widely separated. The intervening mass was here less soft and vascular than was the case over the vault, and in the latter re-

gion the external surface of the outer tables had a bluish, congested appearance, only a thin shell of the tables remaining.

The specimen was sent to the Detroit Clinical Laboratory for examination and the report received is as follows: "Piece of skull , piece of bone about 4 cm. square, outer surface smooth, inner surface consisting of a soft fungating growth. The inner table and diploe are absorbed by a new growth which has also affected the outer table. This new growth consists of round cells with no fibrous stroma. It has a large blood supply and in many parts is infiltrated with blood.

"Morphologically and functionally this growth is a round-celled sarcoma. Portions of brain removed were too much softened before getting into the fluid to permit of examination."

Save some slight hardening of one or two basal vessels, no other abnormality was noted. Here, then, was a sarcomatous growth entirely confined to the cranial bones and from the wide separation of the outer and inner tables, probably of diploic origin. It is interesting to note the headache and ocular symptoms which gave rise to the suspicion of a basal growth.

270 Woodward Avenue.

SURGICAL TREATMENT OF CRANIAL TUMORS.*

By ANGUS McLEAN, M. D.,
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The cranial wall is subject to growths similar to other osseous structures of the body, namely, exostosis, osteoma, sarcoma and gumma.

Tumors of the cranial vault are much easier to diagnose than those situated within the cranium. The former, owing to their position, may be inspected and many evidences of their presence, such as enlargement, protrusion, tenderness on pressure, pain, etc., noted, while the latter present no external evidences whatever and are beyond any local examination.

When these growths extend only towards the interior of the cavity, they will present symptoms similar to those of tumors of the meninges or the cortex of the brain.

With the exception of gummata, these lesions are benefited by surgical intervention only, and when confined to the cranial wall they should be removed, with exception in the case of secondary malignant growths. Owing to their position just beneath the scalp, little trouble is experienced in their removal, as quite large portions of the cranial vault may be taken away without serious results.

Intra-cranial tumors may be situated anywhere within the cranial cavity, and, excluding hæmatoma, are of the following varieties, in their order of frequency, from reports of different authors:

Tubercular gumma, glioma, sarcoma, cyst, carcinoma, syphilitic gumma, psammona and fibroma.

Tuberculous tumors are more prevalent in childhood, while glioma and sarcoma are found chiefly in the adult.

With the exception of syphilitic gummata, these tumors are amenable to surgical intervention only.

As to prognosis, much depends upon the locality and nature of the growth, for tumors of the base of the brain, internal capsule or basial ganglia are almost beyond the reach of surgery, while the con-

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vexity and the sides of the brain are comparatively easy of access.

No classic symptoms present themselves to indicate the precise character of the tumor. A benign or a malignant growth may produce the same symptomatology.

The manifestations depend not on the kind of tumor, but on its location, for a pressure on the motor area would present a chain of symptoms different from those resulting from pressure exerted at the cerebellum; or, a multiple condition is possible.

Some classical diagnosis should be made before interference is attempted, such as a determination as to whether the tumor is cortical or sub-cortical, and whether it is of primary or of metastatic origin, syphilitic or non-syphilitic.

If the lesion can be diagnosed with any degree of certainty as being situated in the cortex, of primary origin and non-syphilitic, its removal should be immediately attempted.

Since the advent of aseptic surgery, tumors situated in an accessible portion of the brain may be attacked with comparative safety. The cranium is opened for two purposes in connection with these growths, relief of pain and pressure and radical removal of tumor. A palliative operation is justifiable when pressure and pain are severe and other symptoms point to a localized era. Great temporary relief follows operation in some of these cases from removal of a portion of the cranial wall, allowing the tissues beneath to protrude or bulge into the opening. When the location of the lesion has been decided upon by the methods of modern cerebral topography, the skull may be opened freely by one of several procedures. By the use of the trephine, electric saw, Gigle saw, chisel and mallet, and other devices, the desired portion of the skull may be laid bare, the surface of bone removed and meninges and brain exposed. Later operators are in favor of the osteoplastic flap; by this method, a U-shaped incision is made through the scalp down to the bone, the soft tissue crowded away, the bone cut through and the flap turned back, leaving the bone attached to the scalp, the portion of bone being returned when the wound is closed. The vessels of the dura mater should be ligated, using small curved needles to carry the ligature around them before they are incised. The same procedure may be followed in controlling hæmorrhage of the pia mater. If the tumor is imbedded in the brain substance, the cortex may be incised, and the deeper tissue examined. Upon the character of the tumor depends much as to the possibility of its successful removal. Fibroma, psammona of the pia mater and cysts are easily outlined and extirpated. These, unfortunately, are the rarer growths. The glioma and the sarcoma are the varieties of lesions that are most commonly found in the deeper brain-tissue. These have no capsule or defined border, and the gliomata are frequently soft and very vascular, offering many difficulties in their complete removal, for they are usually surrounded by important brain areas that must not be interfered with. They may be scooped out with a spoon or a dull curette, and the cavity packed with sterile, aseptic gauze. The results following an attempt at removal of these malignant tumors of the brain have been so unsatisfactory that many noted surgeons, Von Bergmann and others, do not encourage an attempt at complete removal.

The wound is customarily dressed by being packed with a narrow slip of gauze, closing the wound by stitching the dura in position and bringing over the osteoplastic flap, the opening being completely closed excepting the space for gauze drainage.

While much has been done in this line of operative surgery and some brilliant results reported, only a small per cent. of intra-cranial tumors may be operated upon with any degree of ultimate success. Park reports six recoveries from 100 cases, taken indiscriminately; Starr reports 21 successful cases in 300 operated, and other operators give about the same percentage. The per cent. of successful cases deduced from the statistics available is only 6½, and must be considered anything but encouraging.

57 Fort Street West.

IS THE GENERAL PRACTITIONER FAIRLY PAID? IF NOT, WHY NOT?

By ALVAH N. COLLINS, M. D.
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The question of fees is as old as medicine. If a whole class of coworkers in any department of service were to be asked about their wage, whether or not they were properly remunerated for their services to all the other tribes of workers, one universal "No" would be registered. This dissatisfaction, universally widespread, shows to the analyst the impossibility of satisfying laborers in any field of service.

If we grant the assumption that all are underpaid, we cannot escape the conclusion of a fairly just equalization, as all classes are interdependent. If the artisan is underpaid, he gains what he may consider his due by underpaying his tailor, his butcher and his doctor. So the equalization continues *ad infinitum.*

This holds as true with physicians as with carpenters. That we are fairly paid as a class of workers in the general vineyard of human industry is a question perhaps more rightly answered by a noncombatant in the field. No doubt we would prove to be far from an unprejudiced jury.

The question of relative remuneration of those engaged in the same line of work cannot be so equalized. Only the broadest sense of justice and fairness in those constituting our profession can equalize this.

*Read before the Wayne County Medical Society.

In law and in medicine, as in almost no other avocations, the professions themselves very largely fix their own fees. We are, with the exception of those of the law, the last association of workers that should complain of being underpaid. In the law, courts fix fees and fix them on a scale that is liberal and broad. Retainers demanded, and therefore gotten, by lawyers, are fixed on a generous scale by that profession. Pay in advance, before a tap is done or a night's sleep has been lost. They have shown much business sense in securing liberal pay for their services. The medical profession has infinitely more power to fix its wage than any other class of men. Our services are absolutely indispensable. We are required to usher life in, preserve it, and finally to soothe the snapping nerves as they, worn out and incapable of further service, let go the vital mystery. This is, indeed, a great trust. No other service of man to man can for a moment compare with it. All other services deal with place, comfort and condition. Ours, with our very existence added to all the others.

Occupying this strategic position of indispensability, that our profession has not helped itself to the most comfortable houses, the biggest incomes, the fruits and sweets of the earth to a degree that would have brought to our doors, as supplicants, all the coal barons, all the mag-

nates of corporations, the kings and potentates of the earth, is the crowning glory of our service to the human family; that, having the power of indispensability, we have never abused it, we have never used it to take unfair advantage of our fellow workers. We have never assumed the position to which we are entitled. We have never taken advantage of weakness. We have never combined to sell our services, as others have their wares, for the last farthing that could be wrung from the necessities of our fellow man. Have we not shown a magnanimity unparalleled?

To have profited by this power of indispensability would have required an organizer we have never had in our ranks; an organization we have never attained, an organization that none of us wishes to attain.

It would be interesting to catalogue the various causes that have graded our profession into so many classes, ranging from the not paid at all, through the underpaid, well-paid, over-paid, and highway robbery classes.

Among the causes would be found, first and foremost, the varying capacities of men for our particular work. Another large group of causes would be found in the very nature of our work, so multitudinous in its requirements that its varying needs seek out our varying adaptabilities. The self-evident fact of varying adaptability must necessarily produce grades of usefulness, therefore, grades of remuneration. Did our gradation and remuneration always follow along their natural lines, truly no fault should be found by any of us.

Graded remuneration founded upon real value of service is logical and right. It would be folly to try to counteract the natural laws of difference in adaptability and usefulness in medical services as along other lines of human endeavor, for we would find ourselves in that class who really believe that by some hocus-pocus of legislation the sweets of life should be equalized and burdens evenly divided, that each man be made as rich, as handsome, as speedy, as skillful, as industrious or as lazy as every other man.

As well might we content that each physician should be equally honored and equally well paid. Has one those adaptabilities which lead him to select special lines of work, which enable him to perfect himself in those lines to a point beyond that of others, to a degree that his special knowledge or skill has a market value owing to its scarcity, or, if you choose, a value regulated by the law of supply and demand, his fat fees are logical and legitimate. Who can defend a selfishness that would ask him to share them with one who had never earned an honest right—by knowledge, skill or service—to share them?

In legitimate work of this kind a demand upon our specialist for part of the fee would be manifestly unjust. If our dignified specialist found it to his advantage to show his appreciation of his lowly confrère's kindness in selecting him to do the work, I see nothing in morals or ethics that should cause such moral spasms as we sometimes note when this subject is mentioned. The patient should not be robbed to pay for his courtesy. While this question of the financial relations between the specialist and the general practitioner, or the more delicate question, the treatment due the on from the other, has little bearing upon our question of proper pay for the general practician, it has a most important bearing in educating the public to a proper appreciation of the value of medical services. The larger fees demanded and gotten by specialists are wholesome and most beneficial to the rank and file of medical workers. How incomprehensibly unwise it is to do what is often done; a physician complains to a patient

that the consultant or specialist has charged too much, hoping to ingratiate himself with the patient by agreeing with him that he has been robbed, but, in reality, cheapening himself and all his brethren in the public eye, thus hugging to his heart the low fees of the general practitioner of which he justly complains.

The best results to specialist and general practitioner alike can come only through harmonious and helpful co-operation, each working for the best interests of the other, and thereby working for the general good of all. If I call a consultant or a specialist to assist me, I am bound to stand by him in his efforts. If the patient is dissatisfied I believe it for the best interest of both physician and patient to guide him to a different way of looking at the matter if he feels himself aggrieved. I occupy a position in the case which enables me to do this. In turn, I expect the consultant or specialist, by word, act and deed, to guard my interests as he would his own.

If I call an abdominal surgeon because of his reputation or because of peculiarities of the case or condition whereby I deem it best for my patient to have his services, in return for the compliment of selecting him from several equally fitted for my purpose, I expect him, not to divide his fee, but to protect my interests with the family and friends. I do not expect him to go into the family and remove the next corn or bunion they may have, but to direct them back to me, as I usually treat corns and bunions myself. I conceive this to be his duty to the profession if he wishes to maintain that relation between the general practician and consultant which is most conducive to our general welfare. General practicians usually receive this treatment from consultants and specialists. They are, as a class, broad, liberal-minded men whom we delight to honor and to claim as part of our body. From my observation I can truly say I believe them more scrupulous in guarding the best interests of the general practitioner than he is in guarding theirs.

We cannot blame the liberal fees of the specialist for the insufficient fees of the general practitioner. We cannot look for an equalization of fees in percentage or division. Neither strikes at the root of the malady, neither can possibly contain the remedy.

I will make the bold assertion that in the general practician himself is found both the cause and the cure of inadequate fees for the laborious and exacting duties of the rank and file dependent upon general practice for their own and their family's comfort.

General practicians, as a body, are indispensable both to the public and to the specialist. We possess the power of indispensability, given which, nothing but our own stupidity, as a body, prevents our exacting just and reasonable remuneration.

Are we underpaid? Why are we underpaid? Possibly we are not. If not, we have nothing to complain of. We are in a position, as I have said, to fix our own fees. We must not abuse our power and fix them too high. That would not be in keeping with the proud traditions of our noble profession.

Our profession claims, and justly, that the welfare and happiness of the human race is the goal at which it has ever aimed. Our code of ethics has never been equalled by any other body of men in its unselfishness and its tendencies to benefit those whom we serve. It has ever put the welfare of others above our own. We must be our own judge and jury as to the amount of our remuneration for this work. To be judge in our own case implies care that we judge justly. The young man who devotes ten years of his life to preliminary medical and hospital preparation, who brings a

clear head, clean hands, clean character and enthusiasm for his work to the service of his fellow man, should be entitled to a competency at the age of sixty, with means to properly educate and protect a family. Does he get it in general practice? He has been on duty, night and day, for thirty years; he has suffered with the suffering; his home has been at the mercy of the public; he has been misjudged, abused and maligned, and he has been loved, respected and idolized. But for his life insurance or a fortunate investment, how much does the average practician leaves to his family? As a rule, not much.

Until recently we had another general practician who left the plow or the saw with a very imperfect common school education. He took two courses of six months each in some of the many fame-to-the-faculty medical colleges. He needed no hospital experience. He got through largely because he paid more to the infamous college if he got his diploma. He rented a couple of rooms, borrowed or bought a bicycle and hung his sign alongside the honestly equipped man. If he was shrewd he made much more daily than he would with the saw or plough. He was in a position to make visits for from fifteen cents up, and flay the life out of other doctor's reputation within range of his voice. He never knew what the study of medicine meant. He knew nothing, and cared less, for our traditions and was, therefore, a menace to honest medicine, honest fees, and an unmitigated curse to both the profession and the people who employed him. That class of general practician is less common now than some years ago, yet still exists. He is fully paid and more than paid at twenty-five to fifty cents per visit. We have him with us; we cannot ignore him, and how are we to minimize his influence in scaling the fee bill down to a mere existence and in lowering our profession in the eyes of all observers? Experience has shown, over and over again, that the judgment of the people does not protect them from this class.

When I came to this city, in 1888, the most arrant humbug was driving about in his carriage, treating the most wealthy and influential people of our city. True, a couple of years sent him to fields and pastures new, but the evil effects of his sway are an injury to rational medicine to this day. Many instances will come to you all of the inability of the people to chose their medical attendant wisely. But it is the bearing of this class upon proper fees that interests us on this occasion. We must ignore this class in fixing a legitimate fee. Those who compose it have one commendable trait. They admit in their charges that if their services are worth little they do not charge much; then, again, such work usually makes more demand for competent service.

Thanks to some of our old stalwarts in Michigan, our laws are now rapidly eliminating that class. We hope our better organization of medical men, now in full operation, will in a large measure negative its influence for evil.

We have still another class, i. e., the competent physicians who are largely responsible for our inadequate fees, for the long continuance of unpaid bills, and for the fact that the doctor is the last man paid among all classes of our people. This class—the backbone and sinew of our profession—I am going to charge with being more in fault than any other. I will assert, without fear of contradiction, that only by following one plain can this be remedied.

Dr. A. cannot change his prices or methods of collection without bringing upon himself the censure of his patients, so long as Doctors B., C. and D., his neighbors, continue in the old way of al-

lowing their patients to pay them when and what they choose. In one section of the city a fairly competent physician will take a case of obstetrics, see that the woman has proper care before, during and after confinement for from five to ten dollars, to be paid when they feel like it. It may be seven dollars, or it may be ten dollars; one is about as absurd as the other. If he is competent, he must make several urinary analyses; he must see the patient at his office or at her home two or three times, at least, before confinement; he must hold himself in readiness to respond to the call at any hour, day or night; he must drop whatever work he may have at the time. He will spend, on an average, five hours at the bedside. He will assume the responsibility of two lives and the happiness of a family. He will make from three to five or more calls after confinement. He will see that it is all left as it should be when his patient has recovered—all for the insignificant fee of five, eight or ten dollars.

Is that a proper fee for such services, for services which come to each family only four or five times in a lifetime? Who among us would not from choice perform an ordinary appendectomy or oöphorectomy, or remove a mammary gland, so far as responsibility, danger to life and skill required, rather than care for the average primipara? Are the fees for such work equal and just?

How can Dr. A. correct this abuse if Doctors C., C. and D., on the next corner, will continue to do this kind of work and then book the account to be paid when the interested parties have paid all the others connected with the case, have a new baby carriage and are well on toward need for his services again.

Who is to blame for this state of affairs? Not the specialist, surely. He had nothing to do with it. We are. You will admit that this is no fanciful picture. It is a common, everyday experience. How can we correct it? By every member of this Society at once saying he will not care for another case, able to pay, for any such fee. But I will not get so many cases, some one will say. You need only one-third as many cases, and do one-third as much work for the same money, and, at the same time, help your neighbors on all sides to get fair pay for their sleepless nights. You may, by chance, have an evening to go to the theatre with your wife, if you do not have so much work. Now nearly all of our general work has gotten into the same rut, and the same remedy exists. Shall we use it? How can we use it? By starting in and charging a fair fee for our work, by advising our neighbor to do the same, by making a new system of dealing with patients with whom we have been lax; by supporting each other, instead of trying to build ourselves up at our neighbor's expense.

The pernicious way some physicians have of joining in with a dissatisfied patient to run down his neighbor is responsible for much that we have to contend with. Every time we speak a word against a reputable worker in our profession we lower the entire profession somewhat, and we lower ourselves a great deal. Do not do it, it is poor policy. It injures that community of interest upon which much of our success and happiness depends.

Are we entitled to higher fees? In the confinement case cited, the physician would not make fifty cents an hour, if paid by the hour for the actual time consumed. If I take my automobile to the shop I pay as much for a man to pound insensate iron and brass. Are our services worth more per hour than those of a tinker? They should be. Let us make them so.

How many times have you gotten up in the middle of the night and driven out into the city, and charged in your book less than you could have hired a livery man to take you there and back? Is this right? It is with you to adjust. The men who are well paid are well paid as largely because they demand it as because their services are more valuabl than yours.

In the office of one of the members of this Society, whom you all know, there hangs on the office door where patients must see it:

OFFICE CONSULTATIONS CASH. KINDLY TAKE NOTICE OF THIS RULE BEFORE BEGINNING YOUR CONSULTATION.

If every man in this Society will pin that, or a similar notice in his office and make it effective, he will benefit every other physician around him. He will help to educate the people that our services are never forced upon them and, when we serve, that the laborer is worthy of his hire. There is need of it. Let us do it. One, two or three cannot, but we all can and should. We can accomplish the paradoxical feat of raising ourselves by our own boot-straps if we will only do it. Let us all insist upon more prompt payment of our accounts. There is not a business in the city of Detroit that would not be bankrupt in one year if he did business as we general practicians do our business.

Why do we dot it? Let us do business as business men—charge a fair living fee, insist on payment, and help one another. I am glad to see a better feeling, more brotherly and helpful, among medical men. We cannot succeed by pulling one another down; we ought not to succeed by such methods. Any man in our profession that does a tricky, dishonest, mean act toward a fellow practician, whether he be homeopathic or regular, lowers the general standard of the profession that much, and lowers himself most of all.

We general practicians are not enemies of the specialists. We all belong to the same body. We recognize their services as supplementary to ours. Their success depends upon our recognition of the value they are to us and to our patients in a large measure.

There are some abuses that the general practitioner can and should correct. In this question, "Is the general practitioner fairly paid," we are contrasting ourselves not only with other avocations but with those following special lines of work. We are not so well paid as specialists. I have endeavored to show that it is almost wholly our own fault, not the fault of the specialist.

What right has the man who draws from the whole profession by reason of his special work to enter our field when he can slip a few dollars into his pocket by general work? We have no limitations to our work, except inability to do the work well. If the general practician can treat a catarrhal conjunctivitis as well as any one (and if he is well informed he can), this becomes general work; but, can the same be said of the eye specialist or the abdominal surgeon who gets his fat fees because of special knowledge, and in season and out of season lets us know by medical papers, cards through the post and in our journals that he limits his work to certain fields, who secures most of the fees for life insurance examinations that belong to the general practicians? If anything is really left to the general practician after apportioning the body to the various specialists, it is logically life insurance examinations. If anything is left to general practice, that certainly is general enough to suit the most fastidious. This applies fairly, I think, to those who are distinct special-

ists. We do not look for them to take in every other field that chance throws in their way. They, in turn, might say the general practician does work which belongs to him. That is true, but how long could one practice medicine who did not do work that is pre-empted by some specialty. He must examine the lungs and throats of many, he must be able to diagnose and handle all ordinary conditions. If his patient has a gastroptosis and needs a belt he must prescribe it; if he has an abscess he must open it; if he has a broken leg, he must set it.

His is the whole field, bounded only by his inability to give the patient proper care. If I have stated a condition unjust to the general practician, by way of illustration, the remedy is again in his hands. By concerted action he can remedy this and nearly all other conditions of which he complains.

To summarize, from the standpoint of the general practician, we are not proportionately as well paid as the specialist.

We do not believe the remedy is, or can be, in division of fees or percentages.

A bidding for cases by the specialist would simply lead to a cut-rate, cut-throat, undignified state of medicine, which we hope never to see in our ranks.

I see no occasion for moral spasms or righteous wrath, if the patient is not overcharged, should a specialist wish to show his appreciation of the favor shown him by the general practician by equalizing, should he feel disposed to equal up matters somewhat in some special cases.

General practicians are almost wholly responsible for being underpaid by not requiring a fair remuneration and prompt payment for their work. By concerted action this can be easily remedied. By supporting each other in all legitimate work, all that needs to be remedied can be remedied. If those who are able to pay well do so, and pay promptly, those deserving of easy charges and generous treatment can receive it. The general practician can afford to treat more of the needy and deserving who cannot pay, if he is well paid by those who can and should be made to pay.

Can we not bring about some of these reforms, and make a better profession, more useful members of society, and a more contended body of men than we now are?

It rests with the general practician himself, whether he will be fairly paid, independent and respected, or whether he will be a sort of high-toned beggar among men. Ask more and ye shall receive more; demand more and more shall be given unto you.

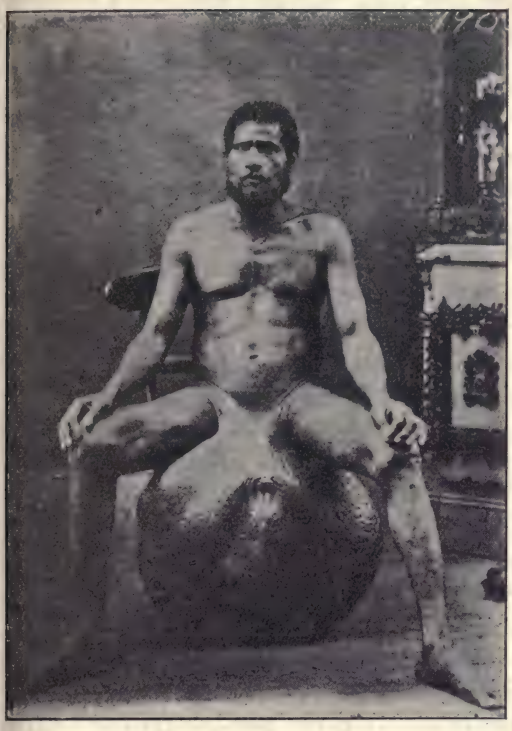
20 Martin Place.

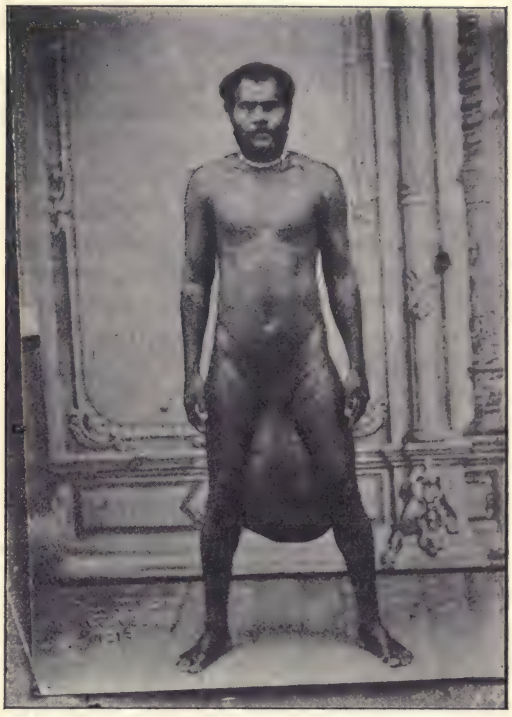
SOME UNIQUE PHOTOGRAPHS.

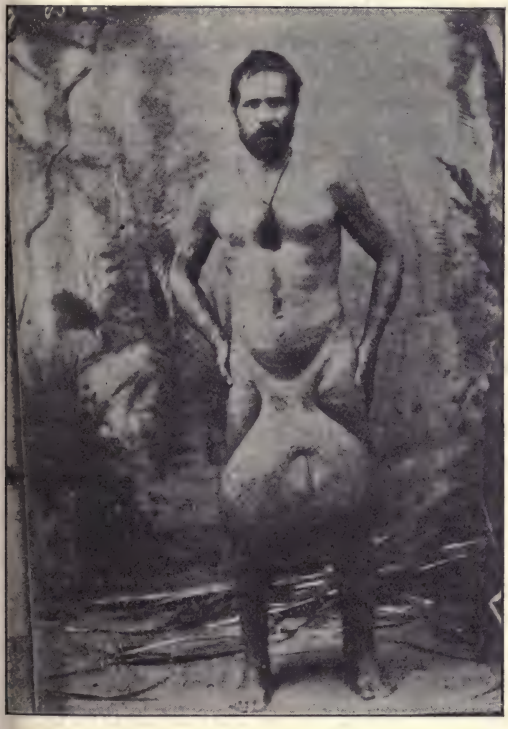
Through the courtesy of Mr. S. P. Miller, of Chicago, we are enabled to reproduce for our readers the four illustrations published herewith. The four original photographs were sent to Mr. Miller by a friend in the Philippines, and show four cases of scrotal elephantiasis, a condition that is not at all uncommon in tropical countries, where the conditions are suitable. Students of tropical diseases are familiar with similar cases, though we believe the photographs published to be unique in regard to the advanced stage of the condition.

Where the growth involves the scrotal region only, the case may be operable, depending on the extent of the new tissue's growth, but two of the cases illustrated show a serious involvement of the vessels of the thigh, to such an extent that operation is out of the question.

The condition is thought to be due to







obstruction of the lymphatic channels by the *filaria sanguinis hominis*; certain cases result from lymphatic obstruction, the result of recurrent erysipelas, ulcers, cicactrices, tumors, etc. Predisposing factors in the etiology are bad food and poor hygiene. Treatment consists of rest, hot or cold applications, and the administration of salines and quinine. Partial exsection or stretching of the sciatic nerve has also been recommended, and in severe cases, compression or ligation of the main artery of the part, and amputation, may be necessary.

It is noticeable that in spite of the enormous character of the growth in the illustrations, the patients appear well nourished and to be comparatively free from suffering.

A unique occasion, in which many physicians of Detroit took part, was the celebration of the wooden anniversary of the Stearns biologic laboratories, held on April 7 last. The laboratories were open to the physicians, and several hundred took advantage of the invitations extended to them to assist in making the date a memorable one. The visitors were taken through the departments by guides, and had the opportunity of seeing a big business in full operation. Regular work was in progress, and visitors were given a chance to see everything they wanted. Everything was in the best of order, and the attention of the visitors was attracted by the manifest care that is used in the preparation of diphtheria antitoxin, streptolytic serum and glycerinated vaccine. The operating rooms for horses used in the preparation of anti-diphtheritic serum are models of cleanliness and modern equipment and the entire plant is on the same scale of excellence. Quarters for 120 horses are provided, and the best care is taken of all the animals housed in the biologic department. This department has grown immensely in five years; when it began operations, three horses furnished the sera.

The guests of the firm expressed great interest in the equipment used, and the evidences of precautions to insure aseptic conditions. A buffet lunch was served in the traveling men's annex, and novel wooden souvenirs were distributed.

The large number of blackmailing malpractice suits against reputable physicians led the New York State Medical association two years ago to undertake to furnish its members with a purely fighting defense proposition; requiring the applicant for defense to agree to fight each case through the court of last resort. The counsel for the association says that statistics show that, during the last few years, throughout the United States, one physician in every one hundred and fifty has been sued each year for alleged malpractice. The medical association, by its work, has decreased the number of these suits. In most of these cases no complaint has ever been served, and in only three has the action been put on the calendar for trial, showing that after one year of this defense an effect on the public was evident. This defense has become so well known that the whole state is covered, and physicians in other cities receive the same defense as those in New York County who are members of the association. Within the last year three of the representative organizations of other states have taken up this same plan of defense.—(*Journal A. M. A.*)

The Solvay Hospital in Delray, Mich., is now incorporated in order that a training school for nurses may be established and the work of the hospital, which is situated in a large and rapidly growing manufacturing section, can be extended.

DETROIT MEDICAL JOURNAL

A MONTHLY EPITOME OF
PRACTICE AND THERAPEUTICS

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The Statute of Limitations in Malpractice.

Actions for malpractice against physicians are primarily blackmail brought to avoid payment of a just bill for medical services or because of dissatisfaction over some unimportant thing in the treatment received or results obtained, which seldom constitutes legal basis for a successful suit. Nevertheless, the defendant is obliged to employ counsel, gather witnesses and ask the support of his confrères because the attack involves his reputation as well as his pocket-book. Statistics show that during the last few years one physician in every one hundred and fifty throughout the United States has been sued each year for malpractice and the annoyance and expense to which the whole profession is thus subjected is easily seen.

Certainly the profession is entitled to all protection possible against these ungrateful black mailers and a united effort should be made in every state to secure such legislative action as will shorten the period during which suit may be brought. Already five states have shortened this period to one year. i. e., Ohio, Tennessee, Kentucky, Delaware and Arizona, while Wisconsin requires that the plaintiff, in order to bring a suit against a physician, must serve within one year a written notice stating the time, place and nature of the injury complained of.

Surely, one year gives ample time for the aggrieved party to start his suit, while delay not only causes the doctor needless annoyance but often serious embarassment in defence through the scattering or death of material witnesses. An imaginary grievance is too often supported by imaginary and manufactured testimony while the defendant must rely mainly upon his professional reputation and the testimony of his experts, not always being able to avail himself of the aid of eye-witnesses of the treatment. Hence, if the doctor has had consultation in bad or obscure cases and death removes his witness, his difficulty in defense is correspondingly increased.

In Michigan and some other states, three years is allowed in which to bring suit for damages for personal injuries, while in many states, as in Michigan until 1899, a statutory limit of six years exists. In many states, including Michigan, the action survives even though the physician may have died during the time. What injustice, that often practically all means of defence have been lost by the death of the physician his estate may be mulcted by suit brought after his death. Such a case occurred in Western Michigan some years ago and the action, which was unheard of during the lifetime of the doctor, was successful for a large sum.

United action of an organized profession is securing many things of advantage in medical education and higher standards for practice, and the same concentrated effort can obtain such modification of the statutes as will materially decrease these increasingly common blackmailing attempts. No system of medical defence

yet devised avoids the loss of time and worry incident to such affairs and any restriction which will discourage these attacks is devoutly to be wished. In general action against physicians for alleged neglectful or improper treatment comes under the same legal classification of injury to the person as governs all actions for damages against municipalities and corporations. Hence, a bill to prohibit suits not brought within one year would be strongly supported by other interests as well as the professional. Limitation to one year would in no sense interfere with a just action against a physician, but would shut out many suits brought later as a bluff at the doctor who may try to collect his unpaid bill.

We commend this matter especially to the Legislative Committee of the Michigan State Medical Society that necessary changes in the Michigan Code may be properly brought before the next legislature.

The A. M. A. Meeting.

Atlantic City, N. J., will be the scene of the fifty-fifth annual session of the American Medical Association, from June 7 to 10 next. The large attendance at the meeting of 1900 at the same place speaks well for the size of the representative body of men who may be expected to be on hand next month, and from long experience Atlantic City knows how to make the time pass pleasantly for the guest within her gates. The advantages of the city from a convention standpoint are well known and almost unlimited, and the railroads have done what they could to make the matter of getting there a comparatively inexpensive one. For the first time, the Association has gotten a railroad rate of better than a fare and one-third; this year's arrangements provide for transportation for members at the rate of one fare for the round trip, plus $1.00. The local committees may be relied upon to look splendidly after the comforts of the members in attendance, and Atlantic City is well equipped with numerous hotels that have a high reputation for excellence. Some of them have a high reputation for prices, too, but it is not necessary for anyone to spend more money than he wishes. There are ample accommodations at a reasonable figure.

The program committee has arranged for an unusually elaborate and valuable representation of America's medical authorities, and the list of papers to be read contains many that should be of great practicability. Every year the annual meeting means more to the members, and every year marks steady progress in the science of healing. No man can go to the June meeting without profit to himself in his profession.

A feature of this meeting that should be of special interest will be the unveiling of a statue of Dr. Benjamin Rush at Washington, D. C., on the afternoon of Friday, June 10. Arrangements will be made for special transportation from Atlantic City to Washington. The Philadelphia profession have prepared plans for a series of special clinics for the benefit of A. M. A. members, to be given at Philadelphia in the week preceding and in that following the convention. They will be held at the University Hospital, and at the Jefferson Medical College and Hospital.

Lack of space prevents us from publishing the complete program of the annual meeting, but it is a good one, well worthy the attendance and the attention of every physician who can possibly be present. Detroit will be well represented. The following papers by practitioners of this city will be read: The Surgical Treatment of Bilocular Uterus and Bifid

Vagina, Dr. H. W. Longyear; The Use of the Stem Pessary for Scanty and Painful Menstruation, Dr. J. H. Carstens; Suprapubic Enucleation of the Prostate, Dr. H. O. Walker; A Report of Some Unusual Intubation Cases, Dr. B. R. Shurly; Vaccine, by Dr. C. T. McClintock; and A Problem in Nutrition, by Dr. Leo Breisacher. Dr. Victor C. Vaughan, of the University of Michigan, will read a paper on Further Studies on Bacterial Intracellular Toxins, as well as one on The Present Status of Streptococcus and Tetanus Antitoxin Injections; Dr. Reuben Peterson, of the same institution, will report two cases of Retention of Urine Due to Retrodisplacement of the Gravid Uterus; and Dr. George Dock will contribute to a symposium on pneumonia a paper on The Value of Internal Medication and of External Local Applications.

EDITORIAL NOTES.

Graduating exercises of the Detroit College of Medicine were held in the Light Guard Armory, Detroit, Mich., on the evening of May 5. It was the thirty-sixth commencement of the institution, and a large crowd was present to cheer the seventy-two graduates taking degrees. The sheepskins were conferred by Dr. E. L. Shurly, vice president of the college, and addresses were made by Dr. James McCarroll, valedictorian of the class, and Dr. Henry W. Heasley. The following students were graduated: Robert C. Allen, Charles H. Anderson, Lester W. Bellows, Albert Bernstein, Julius E. Block, Roscoe Broughton, Jr., George G. Burns, Thomas J. Callan, Clarence D. Chapin, George W. Chisholm, Guy M. Claflin, Oscar G. Crowley, David A. Dickson, Theophilus C. Dolan, Thomas J. Dowling, Charles W. Eastman, George H. Ensing, Claude B. Erwin, John O. Gaston, Arlon H. Gifford, Henry G. Harris, Edward H. Hayward, Randolph J. Hersey, Ernest H. M. Highfield, Jesse J. Holes, George A. Holliday, Richard G. James, George E. Johnson, Karl H. Kellogg, Morris B. Landers, Henry W. F. Law, William C. Lawrence, Charles B. Leonard, Bradford C. Lundy, Alex. J. Mackenzie, John Masselink, Edward G. Martin, Calvin McCarroll, James McCarroll, Daniel McFadyen, James F. MacGeagh, Tom C. McIntyre, Charles H. McLean, Martin E. Nester, Stanley O. Newcomb, Otis E. P. Newsome, Kenneth Noble, Howard W. Pierce, Charles F. Pequenot, Otto L. Ricker, Robert A. Risk, E. Eugene Robb, George P. Sackrider, M. J. Schantz, M. D., Benjamin A. Shepard, De Witt L. Sherwood, Charles E. Skinner, Henry V. Smith, Ralph C. Smith, Okey M. Staats, Ray C. Stone, Philander B. Taylor, Jr., Arthur Turner, George H. Voelkner, Mason E. Vroman, Joseph Wantoch, Felton D. Watts, Bryant Weed, Robert E. Weeks, Archibald B. Wickham, John T. Wood, Charles O. Woodbridge.

After the commencement a banquet was held at the Hotel Cadillac, where more than 400 gathered. Dr. Guy L. Kiefer was toastmaster, and introduced the following speakers: Dr. George W. Chisholm, Dr. Victor C. Vaughan, of Ann Arbor; Rev. Louis Kellinger, S. J., and Dr. T. A. McGraw. At the meeting of the Alumni association, in Harmonie hall, 350 were in attendance, and the recent graduates were admitted to membership in the organization. The following officers were elected: President, Dr. P. M. Hickey; vice president, Dr. M. M. Kerr, of Calumet; financial secretary, Dr. G. C. Bassett; historian, Dr. A. H. Hume, of Owosso; executive committee, Dr. Angus McLean and Dr. W. A. Repp.

NEW INSTRUMENTS AND DEVICES.

Mention of new instruments and devices in this department is entirely complimentary and articles illustrated are judged on their merits.

We invite manufacturers and physicians to send us matter suitable for publication under this head. A description of the device and an electrotype or half-tone with a base not greater than two and five-eighths inches should be sent.

Always mention the price of the article in question.

The management cannot undertake to return cuts unless postage for same accompanies the letter with which they are sent.

Kelly Rubber Cushions.*

It is now seventeen years since I first described my Perineal and Ovariotomy drainage cushions (see *American Journal Obstetrics*, 1887, p. 1029); the following year I added a cushion for general surgical purposes (*New York Medical Journal*, April 28, 1888), and again in 1892 (*New York Medical Record*, Dec. 3), I described the obstetric cushion. Since then these simple aids to our surgical technic have proven sufficiently valuable to come into world-wide use, constantly taking the place of specially constructed tables in extemporized operations, and obviating the necessity for attachments to the regular surgical tables by providing effective drainage from the wound area to the receptacle on the floor. They are of constant service in saving the patient's person from being soiled beyond the field of operation, as well as in protecting the under clothing and night dress, and shielding the beds and sheets from contamination.

The cushions in use up to the present date, while affording efficient drainage, have been open to the objection that they are difficult to clean in the narrow recess of the apron under the rounded rim. I sought to meet this difficulty about fifteen years ago by attaching the rubber apron at the middle of the rounded rim, so that the cushion could be used with either side up, and I then had a cushion made after this pattern by a well-known firm dealing in rubber goods in Philadelphia, but it did not prove satisfactory, as it was too shallow, and I abandoned it.

The lingering objection to the earliest styles of drainage cushions has at last been obviated by constructing the inner surface of the inflated rim in the form of a vertical wall, which joins the floor of the cushion at a right angle, as indicated by the arrows in sectional cut (Fig. 1).

SECTIONAL VIEW

In this way, while all the depth of the original cushion is kept (and even slightly increased), no part is concealed from view, there is no crevice, and perfect cleanliness is possible.

The small square cushion of this pattern, commonly called "perineal" size, is 15 inches wide; the standard operating size is 20 inches wide, and a large operating size is made 24 inches wide. The 20-inch size is the one most generally used (see Fig. 2).

The obstetric cushion is made with a reversible closed sleeve, which hooks up to the rim in such a manner as to catch amnion, blood and placenta, which collected in this pocket can be transported to the bathroom, weighed and inspected, without the use of any other vessel (see Fig. 3).

In using the cushions for gynecological and general surgery, it is best to lay a sterilized towel between the cushion and

*Medical News, April 19, 1904.

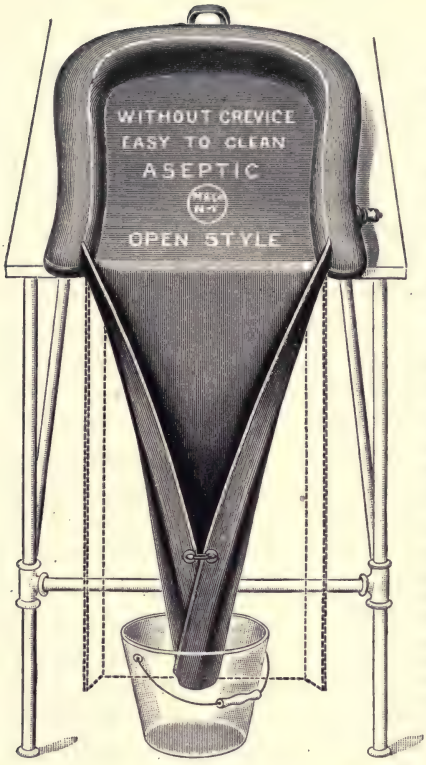
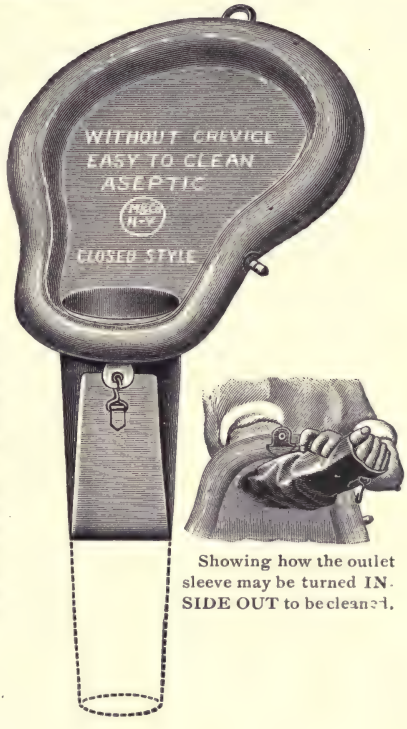


Illustration shows how drainage-apron may be hooked together, thus forming a closed outlet-sleeve. The drainage is thereby carried directly into the receptacle, instead of over the floor and on the operator's clothing.

The dotted lines show how drainage-apron hangs when not hooked together. Notice the gutter or protection, shown by dotted lines, which is formed on each side of the drainage-apron, thus preventing the fluid from running off the sides of apron when used hanging straight down, in the position shown by dotted lines.

Illustration shows how outlet sleeve may be hooked up, thus forming its own receptacle. This makes a drainage pail unnecessary in operations in which there are less than two quarts of fluid present.

Dotted lines show how outlet-sleeve may lead into drainage pail during operations where there are upward of two quarts of fluid present. The outlet-sleeve is *closed*, like the sleeve of a coat, thus carrying the drainage into the receptacle instead of over the floor and on the operator's clothing.



Showing how the outlet sleeve may be turned INSIDE OUT to be cleaned.

the patient. I would also use a sterilized towel or gauze in all obstetric cases. My own practice is to consume from one-half pound to one pound of sterilized absorbent cotten in each obstetric case, unroning and tearing off a good handful of the cotton at a time, and stuffing it between the buttocks below the vulva. When a wad is saturated or soiled, I drop it into the receptacle formed by the apron and substitute another piece. In this way the patient is kept clean throughout. A proper use of the obstetric pad quite does away with the customary washwoman's tax (sometimes as much as $5.00 for a single wash), which she often levies for handling the soiled linen after the arrival of a baby.

I am in the habit of sterilizing my cushions by soaking them for twenty-four hours in a bichloride solution 1-1,000, or even 1-500. This has never seemed to hurt the rubber; the valve of course must be kept out. If there is much odor clinging to the rubber, Labarraque's solution will correct it.

The sixteenth annual commencement exercises of the Michigan College of Medicine and Surgery were held at the Detroit opera house on the third day of the current month, when the house was crowded with the friends and relatives of the graduates, who numbered twenty-six. Prayer was offered by Rev. W. B. Jennings, pastor of the First Presbyterian church, and Rabbi Leo M. Franklin, of the Temple Beth El, made a brief address. Prof. B. D. Cornell, M. D., of Saginaw, made the address of the day, and Dr. Arthur E. Ames was the valedictorian of the graduating class. Vocal music was furnished by Dr. Morgan Parker, and instrumental numbers were played by the orchestra of the theater.

Diplomas were conferred by Dr. Hal C. Wyman, president of the college, on the following graduates:

Harry J. C. Maus, Albert J. Schmaler, Valentine W. Anderson, Andrew J. Moir, Edith May Hunsberger, D. Harvard Irwin, Orizabor Burnett Fritch, Arthur Eugene Ames, Herbert William Case, Henry Montgomery, Herbert E. Gerber, James Ernest Grace, John H. Houton, Hugh L. D. Smith, Fred J. Hohn, Charles T. Bower, Louis Norman Yerkes, George D. Kennedy, Robert Henry Leece, William J. Beery, Felix J. Przybylowski, George E. Orth, Roman J. Sadowski, Fred L. Bright, Marcus R. VanBaalen, Frank Valentine Stutzke.

The following officers of the Alumni association were elected: President, Dr. Burton M. Parker; vice presidents, Drs. J. A. Burke, B. J. Hooper, Peter Dodenhoff, E. R. Ellis, T. W. Tucker; treasurer, Dr. J. E. Burgess; secretary, Dr. William J. Stapleton, Jr.; responder to toast, Dr. Goodfellow, Clio, Mich.

In the evening, at the Wayne hotel, the fifteenth annual banquet of the Alumni was held and the speakers were Dr. Walter J. Cree, Rev. W. Beatty Jennings, D. D., Dr. Frank T. Lodge, Dr. W. J. Stapleton, Jr., Dr. Harry J. C. Maus, Michael Brennand and Carl G. Zeidler.

At the meeting of the Kansas City Academy of Medicine, February 20, Dr. Lewis B. Sawyer read a paper on "Civil Malpractice Limitations." He commented on the absence of specific legislation on this subject, and explained that it was governed by the statutes controlling torts, which in a general way include damage suits of the character under consideration. This rather loose regulation allows complainants to bring suit any time within five years after the alleged injury or injustice has been inflicted, the essayist advocating a specific statutory limitation of one year.

PROGRESS OF MEDICAL SCIENCE

The Rectum as a Bladder.

Dr. J. W. Henson, of Richmond Va. (*Virginia Medical Semi-Monthly*, April 22, 1904), makes a valuable suggestion in the perfection of the operation of Maydl and others for utilizing the rectum as a bladder in cases of exstrophy and malignant disease in which removal of the bladder is indicated. His suggestion has for its object the systematic cleansing of the rectum for some time before it is utilized in its new capacity, and for this he outlines the following procedure:

A few weeks before the operation of bladder-extripation is performed, let an inguinal colostomy be done, severing the bowel and closing the upper end of the lower segment. When union is firm, let systematic irrigation of the rectum be begun; this will, he says, render it a clean sac within a short time, ready for conversion into a bladder. He remarks that he has nowhere found recorded an exactly similar plan. This appears to be a better method than that of Modlinski, who suggested one somewhat similar in 1899. The latter's plan provided that at the time of the implantation of the ureters into the rectum the gut should be severed, at or below the sigmoid flexure, the upper end of the lower segment closed and the lower end of the upper segment stitched in the abdominal wound. Dr. Henson calls attention to the fact that in addition to the objection of soiling the fresh external wound with the fecal current, this plan does not offer a clean reservoir at once.

He suggests the following points on the technique:

"The colostomy should be done in the left inguinal region and in two stages, of course, the steps of the last stage being to sever the bowel completely and close the upper end of the lower segment without entering the abdominal cavity. Reference has been made to the systematic daily irrigation of the rectum, to be commenced when the union is firm at its closed upper end. The solutions for irrigation should be mildly antiseptic and their employment for a week or ten days should render the isolated cavity clean. When about to operate upon the bladder, the fecal fistula should be packed tightly with gauze and the abdominal incision should be made as far to the right of the median line as is possible without embarrassing inspection and manipulation in the field of operation."

X-Rays in Pyorrhoea Alveolaris.

Weston A. Price, D. D. S., (*Archives of Electrology and Radiology*, March, 1904), reports a number of cases in which patients who were suffering from Rigg's disease had been cured by application of the X-rays. His discovery of the service of the treatment in these cases was partially accidental. In treating an aggravated case he had occasion to take several skiagraphs, and finally made an appointment with the patient which the latter did not keep. When he did make a visit several months later, the condition of which he had so bitterly complained was greatly improved, without apparent cause. Suspecting that the application of the rays for the skigraphs had had something to do with the beneficial result, Dr. West conducted a series of experiments on other patients, with gratifying effects.

A number of cases are cited, in which only a few applications served to diminish the flow of pus, close up the pockets

and restore the gums to their normal condition. Through fear of burning the patients, Dr. West made somewhat infrequent exposures, until he was satisfied that the rays possessed great curative power in the treatment of the conditions. At first, the treatment was given through the lips and cheeks; later, he devised an opaque cloth, covering the head and shoulders of the patient, with a hole over the mouth or a part of it. Still later, a tube shield with a mouth-piece was made, which cut off all the rays from the tube, except those which would go through the cone and the mouth-piece. In his latest experiments he used an especially designed tube, which permitted treatment directly against the tissues, both from the outside and the inside of the mouth, greatly simplifying the technique of the treatment. With the tube close to the tissues, only a short time of exposure is required, about thirty seconds at a sitting. The special tube, being used at such close range, does not require great penetrating power, and therefore does not need so large a coil as is generally used. Dr. West warns operators against the cumulative effect of the rays on the tissues of individuals who have been subjected to a number of treatments, and advises great care in protecting portions of the body that must not be exposed.

In view of the simplicity of application and the widespread presence of Rigg's disease, it would seem that Dr. West's treatment should be given a trial. His paper was read before the Cleveland Dental Society, and an interested discussion followed its reading.

Ergot in Alcoholic and Drug Addiction.

Livingston (*Medical News*, March 5, '04), says that his study of this class of cases and of nervous irritability and excitability in other classes, has led to a positive conclusion that the nervous symptoms depend directly on a disturbance of the vascular system in the nerve centers and that the circulatory disturbance is due to paralysis of the sympathetic or vasomotor centers.

The logical corollary is therefore that the prime indication is to tone the relaxed, dilated vessels and bring about as promptly as possible an equilibrium of the circulation. There are several methods by which this result may be wholly or partly secured:

1. Cold to the head and spine by means of ice-cap and spinal bag; or hot followed immediately by cold sponging of the spine, repeating these alternately half a dozen times or more, and such séance several times a day.

2. Galvanization of the chain of sympathetic ganglia by use of the hand electrodes, stroking from occiput to sacrum, the electrodes one on either side of the spine and separated about four inches from each other. The quantity of current should be 10 or 15 milliampères and continued for twenty minutes. This should be followed by similar applications of five minutes each over the upper, middle and lower cervical sympathetic ganglia; or the static current may be used, particularly a prolonged application of the static wave, half an hour or more, to the whole length of the spine with a spark gap of five to eight inches and this séance followed by sparking over the lines of the sympathetic ganglia.

3. Dry-cupping over the entire spine and including the sides of the neck, not with the old-fashioned alcohol cups, but with the modern valve-cups which are emptied by means of an air pump.

4. Massage, which, properly applied by a skilled masseur, is certainly of much service in stimulating the general circulation and, therefore, in relieving congested areas.

5. And last, but by no means the least, effective method, hypodermic injections of ergot. While the other methods may be effective, this is the most certain and the most prompt in its action, because ergot both tones up and strengthens the relaxed muscular tissues and also contracts the muscular coat of relaxed and dilated blood-vessels.

The drug to which the patient is habituated should be absolutely discontinued and the administration of ergot begun at once, the dosage depending upon the degree of drug addiction and the general condition of the patient when his drug is cut off. A half drachm of a reliable fluid extract is given from 2 or 3 times daily up to every 2 hours in severe cases.

There is never any craving after 48 hours for the abandoned drug, and it is unnecessary to use in treatment any of the narcotics or hypnotics if the above plan of therapeutic procedure be rationally carried out.

A Case of Non-Traumatic Serous Cyst of the Iris.

Pooley, N. Y. (*Am. Jour. Ophth.*, March, 1904), reports a case of his rare condition occuring in a man aged 34.

Twelve years previously the patient had noticed a small spot on the iris which had grown slowly but steadily until it reached its present size. No history of trauma could be elicited. There was no pain, no disturbance of vision, only a slight feeling of discomfort.

Examination revealed a large sub-conjunctival hemorrhage covering the whole nasal side of the right eye, the pupil being somewhat encroached upon at its lower border. The lower temporal side of the iris showed a large dark colored mass which closer inspection by oblique illumination proved to be a cyst in the transparent anterior upper margin of the pupil; the edge of the iris was everted showing the back pigmentary posterior surface of this membrane.

The tumor was globular in form, but flattened against the cornea. Diameters each way about 5 mm. Under cocaine a narrow Graefe's knife was passed from the horizontal meridian downwards and inwards over the tumor, making its exit a little to the nasal side of the corneal center. Tumor not injured by the section.

Iris forceps were then introduced and, at fourth attempt iris was seized and cut off, including the greater part of the anterior wall of the cyst. Repeated attempts to grasp iris again resulted in failure.

The edges of the wound were then brought together with a spatula and the eye bandaged. Healing was uneventful.

About six months later, examination showed a small coloboma downwards and outwards. Iris engaged in the scar. There was a brownish pigment spot on the inner side of the coloboma. To the inner side of this was a whitish opacity, evidently a beginning reformation of the cyst. Eye absolutely free from all irritation.

Microscopic examination of the small piece of iris removed showed only rarefied iris tissue; no trace of the epithelial lining of the cyst wall.

Remarks: Failure to remove cyst wall will probably result in a recurrence of the growth. Non-traumatic serous cysts of the iris are very rare, resulting mostly from penetrating wounds of the eyeballs. Regarding the origin, Schmidt-Rimpler suggests that some of the non-traumatic cysts may result from the closure of the crypts normally present on the surface of the iris. An accumulation of the fluid is then assumed to take place so that a retention, or rather exudation, cyst is formed. Berry believes that the serous cyst is a kind of cystoid degeneration of the iris, leading to the formation of a diverticulum at the angle of the iris.

Ureteral Calcuus.

Schmidt (*Journal A. M. A.*, March 12, '04), details an interesting case of the passage of a stone in the ureter after the ureteral injection of oil. In June, 1897, the patient presented the clinical picture of a ureteral calculus which was outlined by a skiagraph taken in December, 1902. January 5, 1904, Schmidt catheterized the ureter and after leaving the catheter in place two hours injected 20 c. c. of sterile albolene in the kidney pelvis and along the ureter; while withdrawing the catheter one week later after severe pains in the right iliac region the patient felt something give way, and soon passed the stone. A subsequent skiagraph showed no stone present in the ureter and all symptoms disappeared.

Water Anaesthesia.

Gant (*N. Y. Medical Journal*, January 23, '04), has found the hypodermic injection of sterile water an efficent local anæsthetic in more than 150 cases, using it in anal fissures, polypi, hæmorrhoids, fistulæ abscesses, division of sphincter, colostomy and exploratory laparotomy. The sensory nerves are obtunded by over-distension of the tissues.

Technique—Deaden the skin by pinching it before inserting needle. Introduce the needle between the layers of the skin and inject a few drops of water until a small wheal is produced, repeating this process along the line of incision, as in Schleich's method. Then the subcutaneous tissues are injected through this line until a firm whitish swelling about as thick and wide as the index finger is produced, when, if the procedure has been properly carried out, anæsthesia is complete. The water may be hot or cold, preferably warm.

BOOK REVIEWS

Von Bergmann's Surgery. A System of Practical Surgery. By Drs. E. von Bergmann, of Berlin, P. von Burns, of Tübingen, and J. von Miculicz, of Breslau. Edited by William T. Bull, M. D., Professor of Surgery in the College of Physicians and Surgeons (Columbia University), New York. To be complete in five imperial octavo volumes, containing 4,000 pages, 1,600 engravings and 110 full-page plates in color and monochrome. Sold by subscription only. Per volume, cloth, $6.00; leather, $7.00; half morocco, $8.50 net. Volume II. just ready, 820 pages, 321 engravings, 24 plates.

The rapidity with which the second volume of this valuable series has followed the first speaks well for the co-operation of the editor and his assistants with the publishers, and promises us that the completed work will be in the hands of the profession before long. It is to be mentioned that the edition published in America is based on the revised German edition, and is therefore considerably in advance of the English edition which has also been translated from the original.

We have taken occasion before now to call attention to the general excellence of the series, which commands our greatest admiration. Its completeness of detail and its exhaustive character make it an epoch-making work, and it is a noticeable fact that it has already been found useful by very recent writers on surgery in the latest medical periodicals. It is so thoroughly in the spirit of modern practice that it covers points not touched upon by other authorities, and when completed it will form a great encyclopedia of modern surgery.

Volume II. deals with the surgery of

the Neck, Thorax and Spinal Column, under the following titles:

Malformations, injuries and diseases of the neck; malformations of the neck; malformations, injuries and diseases of the larynx and trachea; diseases and injuries of the thyroid gland; injuries, malformations of the diseases of the thorax and its contents; malformations, diseases and injuries of the mammary gland; injuries and diseases of the spinal cord and vertebral column; and malformations injuries and diseases of the vertebral column.

The volume is more than handsomely published, and is in every way worthy to take a place in modern American surgical literature.

International Clinics. A Quarterly of Illustrated Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and other Topics of Interest to Students and Practitioners. By leading members of the medical profession throughout the world. Edited by A. O. J. Kelly, A. M., M. D., Philadelphia, U. S. A. Vol. I., Fourteenth Series. Pages, 297. Price, Cloth, $2.00. J. B. Lippincott Co., Publishers, Philadelphia, 1904.

Nearly a decade and a half of publication has established this valuable series firmly in the esteem of the profession. Many practitioners have been attracted to it by the conciseness of its text, the reputation of its editor and his colloborators, and the small price for which it sold. The volume at present under consideration contains many timely and useful communications from authorities in the lines of which they write.

Especially pertinent, in view of the alarming proportions assumed by the scourge of pneumonia in the winter just passed, is a contribution from Nathan Smith Davis, A. M., M. D., who treats of the increasing capacity for harm in pneumonia in the last sixty years, and lays down some excellent suggestions for treatment. Non-operative treatment in inflammations of the genital tract is discussed by Davenport under the section of gynecology, and in the same division Daniel H. Craig makes some suggestions for similar treatment in chronic ovarian lesions.

In the department of sugery, considering progress in 1903, Dr. Joseph C. Bloodgood has a valuable series of contributions on this important subject. Other writers furnish articles which give the fourteenth series a brilliant opening and combine to make the first volume a valuable one, worth more than the price at which it is sold.

A System of Physiologic Therapeutics. A Practical Exposition of the Methods, other than Drug-Giving, Useful in the Prevention of Disease and in the Treatment of the Sick. Edited by Solomon Solis Cohen, A. M., M. D., Professor of Medicine and Therapeutics in the Philadelphia Polyclinic, Etc. Vols. III-VI. Profusely Illustrated. Price, per volume, $2.00. P. Blakiston's Son & Co., Publishers, 1012 Walnut street, Philadelphia, Pa.

This series, the first two volumes of which were reviewed in a previous issue of the *Detroit Medical Journal*, fills a want that is felt by many members of the profession. The reputation of the editor, collaborators and publishers insures a valuable set of books, which should find a prominent place in the library of many a modern physician.

Volumes III. and IV, deal with Climat-

ology, Health Resorts and Mineral Springs, issued in two books, both by F. Parkes Weber, M. A., M. D., F. R. C. P. (Lond.), with the American collaboration of Guy Hinsdale, A. M., M. D., secretary of the American Climatological Association. Book I. deals with Principles of Climotherapy, Ocean Voyages, Mediterranean, European and British Health Resorts, and Book II. takes up the question of the Health Resorts of Africa, Asia, Australia and America. There is also a section on Special Therapeutics, and Dr. Titus Munson Coan, of New York, contributes a special article on the Hawaiian Islands. Both books are capitally illustrated with maps.

Volume V. has for its subject the general subject of preventive medicine, personal and civic hygiene and the care of the sick. Its articles are written by Joseph McFarland, M. D., Henry Leffmann, M. D., Albert Abrams, M. D., and W. Wayne Babcock, M. D. Like the other volumes this one is profusely illustrated. The matters which are considered in it are engaging the attention of municipal and civil governments at the present time, and the book is both timely and authoritative.

Volume VI. takes up the question of Dietotherapy and Food in Health, written by Nathan S. Davis, Jr., A. M., M. D., of Northwestern University Medical School. This is a topic the importance of which is steadily assuming a large place in the considerations of the thinking practitioner, and while it is in a general way a division of prophylactic practice, its importance is so great that it is well considered in the separate treatise.

The notices of volumes VII.-X. will be published in the June issue.

The Medical News Pocket Formulary. By E. Quin Thornton, M. D., Assistant Professor of Materia Medica in the Jefferson Medical College, Philadelphia. New (sixth) edition. Leather, wallet shape for the pocket, $1.50 net. Lea Brothers & Co., ublishers, Philadelphia and New York, 1904.

Full of pertinent suggestions always, this present form of a well known and convenient pocket reminder is again before the profession. Dr. Thornton has brought it down to date, and has made excellent selection from the material at hand in compiling a work that represents the best ideas of modern authorities on therapeutics. The subject-matter is arranged alphabetically for greater convenience, and a few clear suggestions are made as to the special advantages of each line of treatment recommended. There are sixteen pages of valuable data preceding the lists of prescriptions, and these contain enumerations of incompatibles, poisons and antidotes and a table of maximum and minimum dosage. It is a handy thing for the practitioner to have in his pocket.

According to the secular press certain Mt. Clemens doctors are guilty of endeavoring to hold the body of a dead patient as security for an unpaid bill, a procedure unjustifiable under any circumstances. Doubtless a disposition was shown to avoid or shirk obligation regarding the physician's services, but no amount of imposition justifies as a bona-fide procedure, an act so calculated to stamp the brand of commercialism upon the whole profession.

John D. Rockefeller has given $500,000 to Johns Hopkins hospital as an addition to the endowment fund to replace the loss suffered in the great Baltimore fire.

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The first reports of success were followed by others of a less favorable nature; gastric disturbances, cardiac depression and irritation of the kidneys accompanied its use in many cases. These unfavorable and often alarming symptoms occurred in those cases in which the artificial acid or its sodium salt had been used, and were proven by Charteris and others to be due to certain poisonous impurities always present in the synthetic product and emphasized the necessity for the employment of the true acid or salt derived from natural sources.

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